

Department of Veterans Affairs  
Decentralized Hospital Computer Program

# **INTEGRATED BILLING RELEASE NOTES**

Version 2.0

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# Introduction

This release of Integrated Billing (IB) version 2.0 will introduce fundamental changes to the way MCCR-related tasks are done. This software introduces three new modules.

- Claims Tracking
- Encounter Form Utilities
- Insurance Data Capture

There are also significant enhancements to the two previous modules, Patient Billing and Third Party Billing. IB has moved from a package with the sole purpose of identifying billable episodes of care and creating bills to a package which is responsible for the whole billing process through the passing of charges to Accounts Receivable (AR). IB v2.0 has added functionality to assist in the following elements.

- Capturing patient data
- Tracking potentially billable episodes of care
- Completing utilization review (UR) tasks
- Capturing more complete insurance information

IB v2.0 has been targeted for a much wider audience than previous versions.

- The Encounter Form Utilities module is used by MAS ADPACs or clinic supervisors to create and print clinic-specific forms. Physicians use the forms and consequently provide input into their creation.
- The Claims Tracking module will be used by UR nurses within MCCR and Quality Management (QM) to track episodes of care, do pre-certifications, do continued stay reviews, and complete other UR tasks.
- Insurance verifiers use the Insurance Data Capture module to collect and store patient and insurance carrier-specific data.
- The billing clerks see substantial changes to their jobs with the enhancements provided in the Patient Billing and Third Party Billing modules.

IB version 2.0 is highly integrated with other DHCP packages.

- PIMS is a feeder of patient demographic and eligibility data to IB. PIMS also provides information to Claims Tracking, Third Party Billing, and Patient Billing on each billable episode of care, both inpatient and outpatient.

- IB passes bills and/or charges to Accounts Receivable for the purpose of follow-up and collection.
- Prescription information is passed from Outpatient Pharmacy to Patient Billing for the purpose of billing Pharmacy Copayments.
- Prescription refills are passed through Claims Tracking to Third Party Billing to be billed using the Automated Biller.
- The Encounter Form Utilities print data on the forms from the Allergy, PIMS, and Problem List packages. The Print Manager, included with the Encounter Form Utilities, will also print out Health Summaries as well as documents from the Outpatient Pharmacy and PIMS packages.
- Means Test billing data may be transmitted between facilities using the PDX v1.5 package. This may assist sites with the preparation of bills for inpatients who transfer between facilities.

The new functionality seen in this software is the direct result of input and feedback received from field users. Task groups made up of representatives from the field were created under the auspices of the MCCR Systems Committee and MCCR EP. These groups had meetings and/or conference calls with the developers and VACO Program Office (MCCR, MAS, and MIRMO) officials on a regular basis to develop the initial specifications and answer questions that arose during the development cycle. The field representatives on these groups included physicians, UR nurses, MAS ADPACs, MCCR coordinators, and billing clerks. An additional group of users was assembled prior to alpha testing to conduct full usability and functional testing of the software. The input from each of the individuals on these groups was invaluable to the software developers. A full list of each task group and its members is provided in Appendix A to this document.

The software developers would like to express sincere thanks to the seven alpha and beta test sites for installing and implementing this package. Special mention goes to VAMCs San Diego, CA and Buffalo, NY for their hospitality to the developers during site visits for software installation. Thanks also go to the remaining test sites: Augusta GA; Hampton VA; Leavenworth KS; Pittsburgh (HD) PA; and Sioux Falls SD.

These release notes are presented in a different format from previous versions of Integrated Billing. The release notes have been divided into sections for each module. This will allow each section to be targeted specifically toward the individuals who will be using the module described.

An Executive Summary, providing a short overview of the software, will also be provided for management to peruse. These release notes will concentrate on user functionality and not provide technical documentation. Descriptions of the files, fields, templates, routines, and security keys will be provided in the Technical Manual.

**Please ensure that copies of these release notes are distributed to the appropriate users.**





# Executive Summary

## OVERVIEW

This release of Integrated Billing (IB) substantially impacts the way your medical center conducts business. Functionality is included which helps you implement encounter forms in all clinics. You are able to collect and store much more detailed information about insurance carriers and policies related to your patients. The Claims Tracking module allows you to track an episode of care from a scheduled admission to final disposition of a charge. An Automated Biller is introduced with this release which automatically creates inpatient and outpatient bills, as well as bills for prescription refills. In addition to your MCCR unit, this package impacts your utilization review staff, clinicians, and clinic clerks. IB v2.0 is highly integrated with other DHCP packages including PIMS, Accounts Receivable, Allergy, Problem List, Health Summary, Prosthetics, and Outpatient Pharmacy.

## Claims Tracking

The Claims Tracking module provides functionality for the Utilization Review Nurse to do both Hospital Reviews (using Interqual Standards) and Insurance Reviews. It allows for the tracking of an episode of care from the scheduling of the event to the final disposition of the bill. This module is new in IB v2.0 and was added in response to multiple requests from users for functionality to track pre-certification reviews, continuing stay reviews, appeals, and denials. Highlights of this module include the following.

- Events requiring insurance company reviews are tracked from the time of the actual event until payment is resolved.
- Random inpatient stays are selected for Hospital Reviews using the Interqual standards. Severity of Illness and Intensity of Service are recorded for each day of care.
- This module tracks inpatient stays, outpatient visits, prescription refills, and prosthetics and acts as a feeder to the Automated Biller in the Third Party Billing module.
- An Admission Sheet, similar to those used in the private sector, is introduced in this release. This document may be placed in the front of the inpatient chart and can be used to document concurrent reviews.

- The ability to enter comments related to insurance companies or other contacts is included throughout this module.

## **Encounter Form Utilities**

IB v2.0 provides medical centers with the ability to create encounter forms for the purpose of collecting clinical data in the outpatient clinics. Forms can be formatted so as to best fit the needs of each clinic and medical center. Medical centers have the ability to decide what types of data may be printed on the form and what data needs to be collected on the form. There is enough flexibility in the software to allow medical centers to meet their clinical and billing needs with the same form. The encounter form may be used as part of the clinical record. The software is designed to print forms for each scheduled appointment prior to the appointment. Highlights of this module include the following.

- A Form Generator is provided which allows sites to design their own forms. This allows sites to design forms similar to what they are already using.
- Forms may be designed to print with data already displayed for the patient, such as patient demographics, insurance information, allergies, and active problems.
- Through the use of blocks and selection lists, data such as procedures, diagnoses, problems, progress notes, and orders may be collected on the forms.
- A Tool Kit of previously designed forms and blocks is included to assist in the creation of forms so each user will not need to create forms from scratch.
- A Print Manager is included which allows all clinic-specific forms (routing sheets, health summaries, information profiles, and action profiles) to print with the encounter form for an appointment.
- An Import/Export Utility is included which makes it easier for sites to exchange forms that they have already created.

## Insurance Data Capture

The whole concept behind gathering insurance data for billing purposes has changed with IB v2.0. The responsibility for insurance collection has moved from MAS to MCCR with this release. Users will now have the ability to store more detailed insurance information about insurance companies, group plans, and benefits. This data will ultimately help billing and collections more accurately estimate reimbursements from insurance carriers. Highlights of this module include the following.

- Multiple addresses (including main mailing, outpatient claims, inpatient claims, and appeals addresses) may be stored for each insurance carrier.
- Tools are available to maintain and/or clean up the INSURANCE COMPANY file (#36).
- Insurance company-specific billing parameters are available so bills will be able to reflect local insurance company requirements.
- Group plans may be established which will be pointed to by each patient with a policy attached to that plan. This will save the re-input of the same policy data for each patient.
- Annual benefits covered by a plan may be stored. This will be captured by year.
- Benefits used by a patient, such as deductibles and lifetime maximums, may be stored.

## Patient Billing

The Patient Billing module in IB v2.0 went through the fewest substantial changes of the five modules included in this release. This module is responsible for generating all charges that are directly billed to the patient. It was the original module in Integrated Billing, initially designed to create Pharmacy Copayment charges. Since then, Means Test Copayments and Per Diems have been added as well as CHAMPVA subsistence charges. Highlights of new functionality in this module include the following.

- This module is fully integrated with the checkout functionality released in the PIMS v5.3 software package. Patients who claim exposure to Agent Orange, Ionizing Radiation, and Environmental Contaminants and are treated for conditions not related to exposure are now billed automatically.
- Specific stop codes, clinics, or dispositions may be flagged so that they cannot be billed.

- Means Test billing data may now be transmitted between medical centers using the PDX v1.5 software package.
- For outpatient charges, this software now handles the problems caused when billing rates are not received prior to the beginning of the new fiscal year.
- Subsistence charges for CHAMPVA patients are created automatically and passed to Accounts Receivable. This functionality will not be activated until the AR package releases a patch that allows AR to process CHAMPVA receivables.

### **Third Party Billing**

The Third Party Billing module includes changes in three main areas.

- Functionality to generate a UB-92 (which is replacing the UB-82) is included.
- Enhancements to the HCFA-1500 functionality were added.
- An Automated Biller has been created which will be able to automatically generate bills for inpatient stays, outpatient visits, and prescription refills.

Highlights of new functionality in this module include the following.

- The HCFA-1500 has been enhanced to include inpatient as well as outpatient claims so that professional fees can now be billed on this document.
- Through the use of a series of parameters, sites are able to determine what types of events are automatically billed using the new Automated Biller.
- A list of bills created by the Automated Biller is provided. Billing clerks are then able to edit and authorize these bills.
- The ability to add prescription refills and prosthetics items to a bill is provided.

# Section 1. Claims Tracking

## I. FUNCTIONAL DESCRIPTION

Claims Tracking is a new module within the Integrated Billing package that will provide the following six major areas of enhancement.

1. Provide the ability to track billing information about patient visits and services from the time of the event until payment.
2. Track those cases where the insurance company requires reviews.
3. Provide tracking of those cases requiring Utilization Review by the VACO QM office based on Interqual criteria.
4. Track not only inpatient and outpatient visits, but also prescription refills and prosthetics items.
5. Provide the feeding mechanism for automated bill preparation for third party bills.
6. Introduce an Admission Sheet which may be placed in the front of an inpatient chart and used to document concurrent reviews.

Entries to the Claims Tracking module are made automatically. An admission automatically triggers entry of a Claims Tracking record. A pending Insurance Review (MCCR) and/or Hospital Review (QM) are also automatically added, if appropriate. Entries for outpatient visits and prescription refills are added as part of the nightly background job, as these entries are not needed in the same time frame as the admission information. It is important that pre-certifications be done in the time frame required by the insurance carrier.

One of the long-term goals of MCCR has been to provide the ability to track all visits and document why a claim for that visit or service was or was not processed. The Claims Tracking module can run in the following three modes.

- Off
- Tracking of only insurance cases
- Tracking of all cases, based on site parameters

## I. FUNCTIONAL DESCRIPTION, CONT.

There is a place to record reasons why visits were not billed. There is also a place to record the estimated collections. Planned for a future release is the ability to automate the estimated collection based on data in the new Insurance Data Capture module. Incorporating this information into existing reports will hopefully expedite manual billing, and will be used by the Automated Billing module.

The MCCR/UR portion of the Claims Tracking module provides for tracking of cases that require reviews for insurance companies. The center of this functionality is the Pending Reviews [IBT EDIT REVIEWS TO DO] option that provides the necessary tickler file to make sure reviewers are reminded of pending work in a timely fashion. Review information about approvals, denials, penalties, and appeals can be entered and tracked. Appeals and denials can be tracked either by patient or by insurance company. A number of reports are available that can provide valuable information to the clinical staff regarding appropriateness of care. Sites may find that by reducing the number of days of unnecessary care (which are reflected in MCCR by days denied by an insurance company), they may be able to reduce costs.

The Quality Management portion of the Claims Tracking module has little to do with MCCR. It provides for data entry of Utilization Review criteria required by the Quality Management office. The Birmingham ISC is working with the Albany ISC to develop a national UR data base of this information. The initial roll up of this data is tentatively scheduled for June 1994.

This version of Integrated Billing introduces automated third party bill preparation. The various types of visits and the timing of bill preparation are controlled by site parameters. Only entries in the Claims Tracking module will be billed automatically. Currently, this includes tracking of scheduled admissions, inpatient stays, outpatient encounters, and prescription refills. Bills that are given a Reason Not Billable will no longer appear on the lists of visits or admissions to bill, nor will bills automatically be prepared for these visits. While the Automated Biller will be discussed in greater detail in another section, it is important to note that the episodes of care being billed are from the Claims Tracking module.

In non-VA hospitals, a form called an Admission Sheet or Attestation Sheet is commonly used at the front of inpatient charts. This version of IB introduces the Admission Sheet to VA. It is intended to be a one-page document that provides basic demographic information, a workspace for concurrent review, and a place for early sign-off on the Admission Sheet as documentation to support billing prior to sign-off of the Discharge Summary. Many carriers request a copy of the Admission Sheet as additional documentation to be submitted with a claim. It is not intended to be a permanent part of the medical record, but rather a temporary worksheet.

## I. FUNCTIONAL DESCRIPTION, CONT.

There are four user menus for Claims Tracking, which are based on the type of user. There is a menu for individuals who need the full range of UR and billing portions of Claims Tracking. This is designed for use by MCCR supervisors and those personnel who do both Hospital (QM) and Insurance (MCCR) Reviews. There are two separate menus, one each for those sites that have separate personnel doing Hospital and MCCR Reviews. And finally, there is a Claims Tracking menu designed just for personnel in the Billing Unit to allow viewing of UR data as well as updating of billing information.

The primary data display and data entry for Claims Tracking is done through a series of nine List Manager screens. Each screen is associated with a number of actions that can be taken on the data displayed on the screen. The following are the main screens.

1. Claims Tracking data by patient
2. Hospital (QM) Review data by visit
3. Insurance Review data by visit
4. Appeals and associated denials by patient or by insurance company
5. Pending Reviews (hospital and/or insurance depending on the menu)

The first four screens have an associated expanded display of items on the list. This series of screens form the primary display and data input for the Claims Tracking module.

## II. CHANGED OPTIONS

### **Veterans w/Insurance and Opt. Visits**

This option has been changed to reflect the new Claims Tracking module. This report now "knows" about the Claims Tracking module. When running this report, you may choose to include or exclude those potentially billable episodes of care that have a Reason Not Billable entered in Claims Tracking. A new column has been added to print the Reason Not Billable if you choose to print by this option. A new parameter has been added that allows sites to let this report add data to the Claims Tracking module. This is the only automated way to add outpatient care to Claims Tracking prior to checkout. If you choose to add data with this report, no events prior to the Claims Tracking Start Date specified in the parameters will be added. If this report is queued, it will stop if there is a user-initiated request to stop the task.

## II. CHANGED OPTIONS, CONT.

### **Veterans w/Insurance and Inpatient Admissions**

This option has been changed to reflect the new Claims Tracking module. This report now "knows" about the Claims Tracking module. When running this report, you may choose to include or exclude those potentially billable episodes of care that have a Reason Not Billable entered in Claims Tracking. A new column has been added to print the Reason Not Billable if you choose to print by this option. A new parameter has been added that allows sites to let this report add data to the Claims Tracking module. This is the only automated way to add prior inpatient care to Claims Tracking. If you choose to add data with this report, no events prior to the Claims Tracking Start Date specified in the parameters will be added. If this report is queued, it will stop if there is a user-initiated request to stop the task.

### **Veterans w/Insurance and Discharges**

This option has been changed to reflect the new Claims Tracking module. This report now "knows" about the Claims Tracking module. When running this report, you may choose to include or exclude those potentially billable episodes of care that have a Reason Not Billable entered in Claims Tracking. A new column has been added to print the Reason Not Billable if you choose to print by this option. A new parameter has been added that allows sites to let this report add data to the Claims Tracking module. This is the only automated way to add prior inpatient care to Claims Tracking. If you choose to add data with this report, no events prior to the Claims Tracking Start Date specified in the parameters will be added. If this report is queued, it will stop if there is a user-initiated request to stop the task.

## III. NEW OPTIONS

There are four user menus exported with Claims Tracking.

- Claims Tracking Menu (Insurance Reviews) for users who perform only Insurance Reviews.
- Claims Tracking Menu (Hospital Reviews) for users who perform only Hospital Reviews.
- Claims Tracking Menu (Combined Functions) for users who perform all types of reviews.
- Claims Tracking Menu for Billing for billing personnel (on the Billing Clerks Menu and Billing Supervisors Menu).

The Claims Tracking Menu for billing clerks contains only three options, allows input of only billing information into Claims Tracking, and provides billing-specific reports. This section describes the comprehensive user menu with all the options and actions. The options and actions that act differently or do not appear on all menus will be so noted.



### III. NEW OPTIONS, CONT.

#### **Pending Reviews** [IBT EDIT REVIEWS TO DO]

This option will list all pending reviews that have a pending review date during the last seven days. The option is designed to be run the first thing every morning. You should print a Pending Review List sorted by either ward, patient, assigned to, type, or due date, and go to the ward and perform your reviews. You can then come back to this option to perform all the necessary actions on the reviews, or you may use the separate options. This option is available to individuals who do Insurance Reviews, Hospital Reviews, or both. If the individual performs both types of reviews, then a plus sign (+) will appear by the names of patients needing both types of reviews. Reviews are automatically made pending for the day they are added. See the discussions under the Insurance Reviews option and the Hospital Reviews option for an explanation on when reviews are automatically created.

#### **Actions**

Change Date Range - This action allows you to change the beginning and ending date of the search for pending reviews. You can search farther into the past or into the future to find reviews that are pending.

Claims Tracking Edit - This action allows you to jump to the expanded Claims Tracking screen and perform all necessary edits to the entry in that file that are necessary. This may include the input of billing information, if it is known.

Diagnosis Update - This action allows input of ICD-9 diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis, and the onset of the diagnosis for this admission. For outpatient visits, this information is stored with the outpatient encounter information.

Insurance Reviews - This action allows you to jump to the Insurance Reviews screen. For details, see the Insurance Reviews option. Note that if you try to perform an Insurance Review on a pending Hospital Review, the software will automatically take you to the Hospital Review screen. This is not available on the Claims Tracking Menu (Hospital Reviews).

Print Worksheet - This action allows you to print a generic worksheet for selected entries. The latest administrative data is printed on the worksheet, including patient name, ward, physicians, room-bed, etc.

### III. NEW OPTIONS, CONT.

#### **Pending Reviews, cont.**

Procedure Update - This action allows the input of ICD procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional.

Provider Update - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document actual physicians if the administrative record indicates teams or vice versa.

Quick Edit - This action allows you to quickly edit all information about the review without leaving the Pending Reviews [IBT EDIT REVIEWS TO DO] option.

Remove From List - This action allows you to quickly remove the review from the Pending Review List by automatically deleting the Next Review Date. For Insurance Reviews, the field TRACK AS INSURANCE CLAIM is also asked. If this is set to NO, no further reviews will automatically be created for this visit.

SC Conditions - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

Change Status - This action allows you to quickly change the status of a review. Only completed reviews are used in the report preparation. Only completed reviews will be used by the QM roll up (which is tentatively scheduled for release in June 1994).

Hospital Reviews - This action allows you to jump to the Hospital Reviews screen. For details, see the Hospital Reviews option. Note that if you try to perform a Hospital Review on a pending Insurance Review, the software will automatically take you to the Insurance Review screen. This is not available on the Claims Tracking Menu (Insurance Reviews).

View/Edit Entry - This action allows you to jump to either the expanded Insurance Review screen or the expanded Hospital Review screen, depending on the type of review.

## III. NEW OPTIONS, CONT.

**Claims Tracking Edit** [IBT EDIT TRACKING ENTRY]

This option is the main gateway to all Claims Tracking functions (except pending reviews). Each visit, whether inpatient, outpatient, or prescription refill, has a unique entry where it is tracked to see whether or not it is billable. Normally, only visits of insured patients are tracked; however, all visits may be tracked. You can edit information about anticipated revenue and required reviews with this option, and perform a number of maintenance and clinical update edits. Depending upon how you set your site parameters, admissions, outpatient visits, and prescription refills may automatically be added. If you are using the schedule options, then scheduled admissions will also be added. Upon installation, all inpatients with insurance will automatically be loaded into Claims Tracking.

**Actions**

Add Tracking Entry - This action can be used to add an entry to be tracked, if it was not automatically added. This will most commonly be used to add old visits or to add scheduled admissions if you are not using the Scheduled Admission module of the MAS package.

Assign Case - This action allows you to assign a visit to a reviewer. This is useful in sorting pending reviews by the reviewer to whom they are assigned. Insurance and Hospital Reviews can be assigned separately.

Billing Info Edit - This action allows you to edit the billing information concerning expected revenue and next auto bill date. This is useful for comparing expected revenue versus revenue received.

Change Date Range - This action allows you to change the default date range for the list of visits. Normally only the past year's visits are displayed, including any current admission. If you wish to view or take action on a visit outside of the current year, use this action to select the correct date range. Note that for inpatient care, the admission date is used.

Change Patient - This action allows you to change the selected patient without having to leave the option and choose it again.

Delete Tracking Entry - This action allows you to delete a tracking entry. If for some reason an entry was mistakenly added, use this action to delete the entry. Normally, if there is associated data with a review, it is preferable to inactivate the entry using the Change Status action rather than delete it.

### III. NEW OPTIONS, CONT.

#### **Claims Tracking Edit, cont.**

Appeals Edit - This action allows you to jump to the Appeals and Denials screen. For details, see the Appeals and Denials option. This is not available on the Claims Tracking Menu (Hospital Reviews). Only denials and penalties may be appealed.

Insurance Reviews - This action allows you to jump to the Insurance Reviews screen. For details, see the Insurance Reviews option. This is not available on the Claims Tracking Menu (Hospital Reviews).

Hospital Reviews - This action allows you to jump to the Hospital Reviews screen. For details see the Hospital Reviews option. This is not available on the Claims Tracking Menu (Insurance Reviews).

Diagnosis Update - This action allows input of ICD-9 diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis, and the onset of the diagnosis for this admission. For outpatient visits, this information is stored with the outpatient encounter information.

Procedure Update - This action allows the input of ICD-9 procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional.

Provider Update - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document actual physicians if the administrative record indicates teams or vice versa.

Quick Edit - This action allows you to edit nearly all of the fields in Claims Tracking, specify if there should be Insurance or Hospital Reviews, add billing information, and assign the visit to a reviewer.

SC Conditions - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

### III. NEW OPTIONS, CONT.

#### **Claims Tracking Edit, cont.**

View/Edit Episode - This action allows you to jump to the expanded Claims Tracking screen where you can view much of the data on one visit and perform related actions.

#### **Single Patient Admission Sheet** [IBT OUTPUT ONE ADMISSION SHEET]

This option allows you to print an Admission Sheet for one visit. The function of the Admission Sheet is to serve as a temporary cover sheet in the inpatient chart where reviewers and PTF coders can make notes about the visit in summary form. If the facility chooses to have physicians sign the Admission Sheet, it can be used as documentation to prepare inpatient bills prior to the signing of the Discharge Summary.

#### **Insurance Review Edit** [IBT EDIT COMMUNICATIONS]

This option is designed to allow the person doing reviews for insurance purposes to document the following events.

- Contact with the insurance company
- Action taken by the insurance company
- Relevant clinical information
- The need for further reviews

An initial review is automatically created upon admission for all insured patients. If UR is not required for the patient, the review can be deleted, inactivated, or left in an ENTERED status. If reviews are performed, and contact with the insurance company is made, the information can be input into this module. Once a review or entry is complete, its status should be updated to COMPLETE so it will be used in reporting. If further reviews are required, the NEXT REVIEW DATE should contain the date the next review is required. It will then appear in the Pending Reviews option or on the Pending Reviews List.

#### **Actions**

Add Comment - This action allows you to edit the word processing field in the Insurance Review to add or edit this information without having to edit other fields.

### III. NEW OPTIONS, CONT.

#### **Insurance Review Edit, cont.**

Add Ins. Review - This action will add a new review for the visit. The following are the default review types.

- Pre-certification Review (if it is a scheduled admission and no previous review)
- Urgent Admission Review (if it is not a scheduled admission and no previous review)
- Continued Stay Review (for follow-up reviews)

Appeals Edit - This action allows you to jump to the Appeals and Denials screen to add/edit appeals. Only reviews where the action is either a denial or a penalty can be appealed. The denials and penalties can be edited on either the Appeals screen or the Insurance Reviews screen. Appeals can only be edited on the Appeals screen.

Delete Ins. Review - This action allows an Insurance Review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It may be just as important to document that no review is required as it is to document the required reviews.

Diagnosis Update - This action allows input of ICD-9 diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis, and the onset of the diagnosis for this admission. For outpatient visits, this information is stored with the outpatient encounter information.

Procedure Update - This action allows the input of ICD-9 procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional.

Provider Update - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document actual physicians if the administrative record indicates teams or vice versa.

## III. NEW OPTIONS, CONT.

**Insurance Review Edit, cont.**

Quick Edit - This action allows you to edit nearly all the fields in the Insurance Review. The type of review can be specified, along with the action of the insurance company, comments, the status of the review, and a follow-up date for the next review.

Review Wksheet Print - The worksheet generated by this action will be useful when visiting the ward to collect inpatient data. You should collect the data prior to calling the insurance company and entering the data. Basic information is printed about the patient and the visit on the form. Note that the format is slightly different for 80 column and 132 column output.

SC Conditions - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

Change Status - This action allows you to edit the status of a review. The choices are INACTIVE, ENTERED, PENDING, and COMPLETE. An INACTIVE review is no longer listed on the screen. A review is given a status of ENTERED when it is created and updated to PENDING once data entry is begun. The status should be changed to COMPLETE once the review is complete. Note that this would support data entry by non-clinical users, and the status could be updated to COMPLETE once the reviewer is satisfied with the entry.

View/Edit Ins. Review - This action allows you to jump to the expanded Insurance Review screen where you can view expanded data on a selected review and perform related actions. The actions are similar to the actions on the Insurance Review List screen; however, there are some abbreviated input actions that allow editing of only a few fields.

Change Patient - This action allows you to select a new patient without returning to the menu.

### III. NEW OPTIONS, CONT.

#### **Appeal/Denial Edit** [IBT EDIT APPEALS/DENIALS]

This option is slightly different from most Claims Tracking options. You can select either a patient or an insurance company for whom you wish to list the appeals and denials. This option lists the denials and penalties with all associated appeals. This can be used to track the appeals for either a patient or an insurance company. It is very similar to the Insurance Review option; however, if an appeal is approved or partially approved, the amount won on appeal is tracked.

#### **Actions**

Add Appeal - This action allows adding an appeal to a denial or penalty. The first appeal will be an initial appeal. All other appeals will be subsequent appeals. You may enter an administrative or clinical appeal. There is no limit to the number of appeals that may be entered.

Delete Appeal/Denial - This action allows deletion of appeals and denials. This was designed to be used in cases of erroneous entry.

Ins. Co. Edit - This action allows editing of fields in the INSURANCE COMPANY file (#36) that pertain to appeals address and phone numbers.

Patient Ins. Edit - This action allows editing of patient policy information. See the section on Insurance Data Capture for details.

Quick Edit - This action allows you to edit nearly all of the fields in the appeal or denial, add comments, maintain its status, and assign follow-up dates.

SC Conditions - This action allows a quick look at the patient's eligibility, SC status, service-connected conditions, and percent of service connection for service-connected veterans.

View/Edit Entry - This action allows you to jump to the expanded Appeal/Denial screen where you can view much of the data for one visit and perform related actions.

#### **Inquire to Claims Tracking** [IBT OUTPUT CLAIM INQUIRY]

This option will display or print stored information about a single visit. You can select a patient, list the Claims Tracking entries, and view the information. A brief display of the reviews performed is also provided. This display is less detailed than the Claims Tracking Summary for Billing option.



### III. NEW OPTIONS, CONT.

#### **Supervisors Menu** [IBT SUPERVISORS MENU]

This menu contains the options to edit the Claims Tracking site parameters and to manually add outpatient encounters and Rx refills to Claims Tracking.

#### **Manually Add Opt. Encounters to Claims Tracking** [IBT SUP MANUALLY QUE ENCTRS]

Outpatient Encounters that have been checked out are normally added during the IB nightly background job. Only primary outpatient encounters that have been checked out will be added in the first twenty days after the date of the encounter. The purpose of this option is to allow sites to search for outpatient encounters that were not checked out within twenty days and have them automatically added to Claims Tracking. If sites choose to run the automated bill preparation portion of IB v2.0, they will want to periodically run this report to insure that all outpatient care is billed. This option is automatically queued and a mail message is sent upon completion.

#### **Manually Add Rx Refills to Claims Tracking** [IBT SUP MANUALLY QUE RX FILLS]

Rx refills are normally added during the IB nightly background job. Refills that have been released within ten days of the fill date are automatically added at night. The purpose of this option is to allow sites to search for refills that were not released within ten days and have them automatically added to Claims Tracking. If sites choose to run the automated bill preparation portion of IB v2.0, they will want to periodically run this report to insure that all outpatient care is billed. This option is automatically queued and a mail message is sent upon completion.

#### **Claims Tracking Parameter Edit** [IBT EDIT TRACKING PARAMETERS]

This option allows editing of the Claims Tracking parameters. There are a number of parameters designed to limit the automatic addition of information to Claims Tracking for sites that do not have sufficient computer resources to run this module. A site can set the earliest date for adding entries, or turn on or off inpatient, outpatient, and Rx refill tracking separately. There are a number of parameters that also control the random sampling of admissions for Hospital Reviews.

#### **Reports Menu (Claims Tracking)** [IBT OUTPUT MENU]

This menu contains all the report options available in Claims Tracking.

#### **UR Activity Report** [IBT OUTPUT UR ACTIVITY REPORT]

This report is similar to the MCCR/UR Summary Report; however, it counts total activity during the period. It also provides a detailed listing of the Insurance Reviews done during the period, along with a Summary Report. The detailed listing can be sorted by patient, review date, or specialty.

### III. NEW OPTIONS, CONT.

#### **Print CT Summary for Billing** [IBT OUTPUT BILLING SHEET]

This option prints nearly all information that can be determined about a visit. Summary information such as the following may be printed from MAS or Pharmacy.

- Summary information from Claims Tracking
- Information from all Hospital and Insurance Reviews (including comments)
- Diagnoses, procedures, and provider information from Claims Tracking

This report is designed to provide as much detailed information about a visit as possible for use by billers when entering a claim, or when answering questions about a claim.

#### **Days Denied Report** [IBT OUTPUT DENIED DAYS REPORT]

This report can print a summary or detailed listing of denials by insurance companies. The report can be sorted by patient, attending, or service. The Summary Report shows the number of denials, the total days denied, the dollar amount of the denials, and the days won on appeal by service.

#### **MCCR/UR Summary Report** [IBT OUTPUT MCCR/UR]

This report prints a summary of hospital activity by either admission or discharge and the number of reviews for the period. If sorting by discharge, only reviews for discharges for the period are counted. The report includes a Penalty Report, a Days Approved Report, and a Days Denied Report, all by specialty.

#### **List Visits Requiring Reviews** [IBT OUTPUT LIST VISITS]

This option will print a list of visits that require either an Insurance Review, Hospital Review, or both. In addition, only visits that are admissions may be printed. You may select the date range of visits to print. This option can be used to list the Random Sample cases being tracked for Hospital Reviews by answering the prompts that only Hospital Reviews for admissions are wanted.

#### **Review Worksheet Print** [IBT OUTPUT REVIEW WORKSHEET]

This option is similar to the Review Worksheet action on the Insurance Review screen. A worksheet for a current inpatient can be printed containing demographic data and information about current room/bed, ward, and provider.

### III. NEW OPTIONS, CONT.

#### **Scheduled Admissions w/Insurance** [IBT OUTPUT SCHED ADM W/INS]

This option prints a list of scheduled admissions in Claims Tracking for insured patients. This will produce a list of patients with past scheduled admissions and scheduled admissions up to three days into the future. This is not the same as the Scheduled Admission List from MAS, as it does not contain all scheduled admissions from MAS. Scheduled admissions are normally moved to Claims Tracking four days prior to the scheduled admission date so that reviews can be completed prior to admission. The report includes the number and type of reviews performed and the insurance company actions.

#### **Pending Work Report** [IBT OUTPUT PENDING ITEMS]

This option will print a Pending Work List, similar to the Pending Reviews option. It can be sorted by due date, patient, ward, or assigned to, for either Insurance Review, Hospital Reviews, or both. This option will limit the number of reviews on the list to those reviews which meet the sort criteria rather than just sort the reviews. The output generated by this option is different than the output generated when printing the reviews from the Pending Reviews option.

#### **Unscheduled Admission w/Insurance** [IBT OUTPUT UNSCHE ADM W/INS]

This option prints a list of unscheduled admissions in Claims Tracking for insured patients. In addition, it prints information about the number of reviews completed and the insurance company actions.

#### **Hospital Reviews** [IBT EDIT REVIEWS]

This option is designed to allow the entry of the utilization management information required by the Quality Management Office. The Claims Tracking module will automatically identify a random sample of admissions (see the Claim Tracking Parameter Edit option) that require review. Hospital Reviews are the application of Interqual criteria to determine if the admission or continued stay meet specific criteria. This module will allow entry of the category of criteria that was met for Severity of Illness and Intensity of Service, or the reasons that criteria was not met. An entry for every day being reviewed is required. This can easily be accomplished by using the Add Next Review action which is designed to reduce the data entry time by duplicating the entries for days where the information is identical.

A national roll up of this data is scheduled to be released in early summer of 1994. Only reviews with a status of COMPLETE will be extracted.

### III. NEW OPTIONS, CONT.

#### **Hospital Reviews, cont.**

##### **Actions**

Add Next Hosp. Review - This action will add the next review and automatically set it to either an admission review or continued stay review. The day for review and review date are automatically computed but can be edited. The category of Severity of Illness and Intensity of Service that was met can be entered, or if not met, the reason it was not met.

Delete Review - This action allows an Insurance Review to be deleted. If a review is automatically created, but the visit does not require reviews and follow-up with the insurance company, it can be deleted. Use care in exercising this action. It may be just as important to document that no review is required as it is to document the required reviews.

Quick Edit - This action allows you to edit nearly all the fields in the Insurance Review. The type of review can be specified, along with the action of the insurance company, comments, the status of the review, and a follow-up date for the next review.

Change Status - This action allows you to edit the status of a review. The choices are INACTIVE, ENTERED, PENDING, and COMPLETE. An INACTIVE review disappears as though deleted. A review is given a status of ENTERED when it is created, and updated to PENDING once data entry is started on the review. It should be changed to COMPLETE once the review is complete. Note that this would support data entry by non-clinical users, and the status could be updated to COMPLETE once the reviewer is satisfied with the entry.

View/Edit Review - This action allows you to jump to the expanded Insurance Review screen where you can view expanded data on a single review and perform related actions. The actions are similar to the actions on the Insurance Review List screen; however, there are some abbreviated input actions that allow editing of only a few fields.

Diagnosis Update - This action allows input of ICD-9 diagnoses for the patient. Whether diagnoses are input on this screen or another screen, they are available across the Claims Tracking module. You may enter an admitting diagnosis, primary (DXLS) diagnosis, secondary diagnosis, and the onset of the diagnosis for this admission. For outpatient visits, this information is stored with the outpatient encounter information.

### III. NEW OPTIONS, CONT.

#### **Hospital Reviews, cont.**

Procedure Update - This action allows the input of ICD-9 procedures for the patient. You may input the procedure and the date. This is a separate procedure entry from the PTF module and is optional.

Provider Update - This action allows you to input the admitting physician, attending physician, and care provider separate from the MAS information. The purpose is to provide a location to document the attending physician and to provide an alternate place to document actual physicians if the administrative record indicates teams or vice versa.

Change Patient - Allows you to select a new patient and enter reviews for a selected visit without returning to the menu.

#### **Assign Reason Not Billable [IBT EDIT REASON NOT BILLABLE]**

This option provides functionality to flag a visit, inpatient, outpatient, or Rx refill as billable or non-billable. This is done by assigning a Reason Not Billable. If there is no Reason Not Billable assigned, the billing information can be entered into Claims Tracking for the visit. This option appears on the Claims Tracking Menu for Billing and is a simplified edit of Claims Tracking information that is of interest to billing personnel.

### IV. IMPLEMENTATION GUIDELINES

Because Claims Tracking is a new module, you will want to consider how you plan to implement this package. You will probably want to have a meeting with the IRM staff, MCCR Coordinator, MAS ADPAC, and Quality Management/UR supervisor. Discuss how each section plans to use this module. In particular, is MCCR planning on running automated billing? If yes, for what types of bills? Does IRM have the disk space and capacity to support this? In this meeting, you will want to review the Claims Tracking site parameters and discuss how they affect the package. (The recommended settings are shown in the user manual.) The Claims Tracking module has the ability to use a great deal of disk space and capacity if turned on to track all episodes.

#### IV. IMPLEMENTATION GUIDELINES, CONT.

Claims Tracking contains the data entry portion of the QM national roll up of data, and will determine the random sample cases for review. Most sites will be compelled to run this part of the inpatient tracking. If you plan to use the Automated Biller to do bill preparation for outpatient and prescription refill billing, you will also want to turn on tracking of these portions of the Claims Tracking module for insurance cases. There are ways to automatically back load insurance cases into Claims Tracking. If you do not currently have the capacity, or want to delay implementation, you can still take advantage of this module at a later date. We suggest you initially turn on the inpatient Claims Tracking for insurance and UR cases to see how the system works, then implement outpatient and prescription Claims Tracking for insurance cases after a few weeks (only if you plan to use those parts of the package).

The majority of the data entry in Claims Tracking is oriented to the UR personnel. Training is crucial to successful use of the Claims Tracking module. It is suggested that personnel tasked to use this module begin in a training account for the purpose of practice and familiarization. When entry errors occur, the record can be deleted and re-entered if need be. (Use the Print CT Summary for Billing option prior to deleting in order to review what was done.)

Back loading the required QM reviews.

The Quality Management Office is mandating that the UR cases from 4/1/94 be input into Claims Tracking so that this information is available for the national roll up expected to be released in June 1994.

To input these prior cases, use the Claims Tracking Edit option, then use the Add Tracking Entry action and enter the following information as indicated. If other prompts appear, enter nothing or accept the default answer. Responses are shown in boldface type.

- Select Tracking Type: **INPATIENT ADMISSION**  
(Do not enter "SCHEDULED ADMISSION" as it is for future scheduled admissions.)
- Admission Date: **JAN 20, 1994**  
(Enter any date that the patient was an inpatient and the system will find the correct admission date.) NOTE: If you enter dates that the patient was not an inpatient, this will cause you to lose the link to MAS-type information.

## IV. IMPLEMENTATION GUIDELINES, CONT.

- Okay to Add Claims Tracking entry for Admission Date AUG 30,1993@07:44:18? NO// **YES**  
(Notice that the computer found the correct admission date and time.)
- ADMISSION TYPE: URGENT//  
(You can change this if you want. The default is urgent. Enter a question mark for a list of choices.)
- TRACKED AS INSURANCE CLAIM?: NO// **<RET>**  
(The default value at this prompt will depend on whether or not the patient is insured.)
- REASON NOT BILLABLE:  
(If this appears and you do not know the answer, leave it blank.)
- SPECIAL CONSENT ROI:  
(If this appears and you do not know the answer, leave it blank.)
- TRACKED AS RANDOM SAMPLE? NO// **YES**  
(Enter "YES" if this is a random case; "NO" if it is not.)
- TRACKED AS SPECIAL CONDITION NONE// **COPD**  
(If this case involved TURP, COPD, or CVD, enter your choice or press <RET> to leave it blank. Note that a case can be both random and a special condition.)
- TRACKED AS A LOCAL ADDITION? NO// **NO**  
(Enter "YES" if you are doing UR on this case as a locally determined case to follow; "NO" if you are not. If no answer is entered, "NO" is assumed. Note that the way in which you answered the previous two questions has no effect on this field.)
- HOSPITAL REVIEWS ASSIGNED TO:  
(If you track cases by who did the review, enter the name of the user assigned this case for Quality Management Reviews; otherwise, leave blank.)
- INS. REVIEWS ASSIGNED TO:  
(If you track cases by who did the review, enter the name of the user assigned this case for Insurance Reviews; otherwise, leave blank.)

#### IV. IMPLEMENTATION GUIDELINES, CONT.

Now use the action Hospital Reviews to go to the Hospital Review Input screen. If you have your worksheets in front of you, use the Add Next Review action to enter your reviews. An entry for every day of the review period is required. If the entry for succeeding days is exactly like the prior day, answer " YES" to the question, "Is this exactly like the previous review?", until you are done. You can edit any of these reviews later. Remember to enter a Next Review Date if you want this to show up on your pending work report (or To Do List). The status of each review must be COMPLETE in order for the National roll up to extract the data.

When you finish entering reviews for this patient, return to the Claims Tracking Edit screen and use the Change Patient action to select the next patient and repeat the procedure.



## Section 2. Encounter Form Utilities

### I. FUNCTIONAL DESCRIPTION

An encounter form is a paper form designed specifically for an outpatient appointment. It is used both to display relevant patient data for use during the appointment (such as demographics, allergies, and problems), and to collect data about the appointment (such as procedures and tests performed). Its focus is primarily clinical, but it has other purposes (such as collecting data necessary for billing).

The Encounter Form Utilities are a set of options that allow encounter forms to be

- Designed, edited and assigned to clinics;
- Printed for appointments with patient data;
- Printed with or without patient data for patients without an appointment.

The Encounter Form Utilities enable collection of outpatient clinical and administrative data. They provide a more organized method of data collection which is less obtrusive to the clinician and supporting clerical staff.

The utilities include a Print Manager that allows sites to define reports that should print along with the encounter forms. This should result in a considerable savings in time required to collate the various reports and forms printed for each appointment. Reports can be defined to print for entire divisions or for individual clinics. Also, at the division level, conditions can be specified under which the reports should print (such as "for all appointments" or "only for the earliest appointment"). Currently, the Routing Slip, Information Profile, Action Profile, and any Health Summary can be printed via the Print Manager. Other forms will be added, depending on demand by local sites. There is an option that local sites can use to add their own reports for use by the Print Manager.

Many sites already use encounter forms of their own design. For this reason, a "form generator" was created, rather than a set of pre-formatted encounter forms. This allows sites to design forms similar to the ones they may already use. The form generator displays the form to a portion of the screen with a coordinate system drawn across the top and left side so that the position of its contents can be determined. Objects can then be created and placed on the form. Many actions are included which are meant to ease the burden of creating forms. For example, users can copy a form that someone else designed and then edit it, or they can copy a block from another form and place it on their own form. Users can move a single block on the form or shift entire groups of blocks. There are a variety of object types that can be created and placed on the form. Learning the terminology that was

## I. FUNCTIONAL DESCRIPTION, CONT.

invented to describe these objects is the biggest hurdle to overcome before personnel at a site can successfully use the utilities to design their own forms.

The Encounter Form software interfaces with DHCP to display patient data. Currently, data displayed on the encounter forms comes from the PIMS, Allergies, and Problem List packages. Data that can be printed to the form includes patient demographic and insurance data, patient allergies, and problems. In the future, more interfaces will be added as they are requested by users. The utilities are designed to interface in a well-defined manner with other packages so that new interfaces can be easily added. There are options for use by local IRMs that enable them to easily add their own package interfaces.

The utilities include a "Tool Kit" of forms and form components so that sites do not have to spend a lot of time creating custom forms. In most cases, the Tool Kit will meet the needs of the local sites, allowing them to avoid the time-consuming process of creating forms from scratch. There are options to allow sites to edit the Tool Kit. There is also an Import/Export Utility that will enable sites to exchange forms and form components. It is important to note that after the Tool Kit is initially installed, additional forms, contained in Files #357 - #357.5 and #357.77 - #357.8, can only be installed through the Import/Export Utility. Data for these files should not be transferred via DIFROM after the initial install.

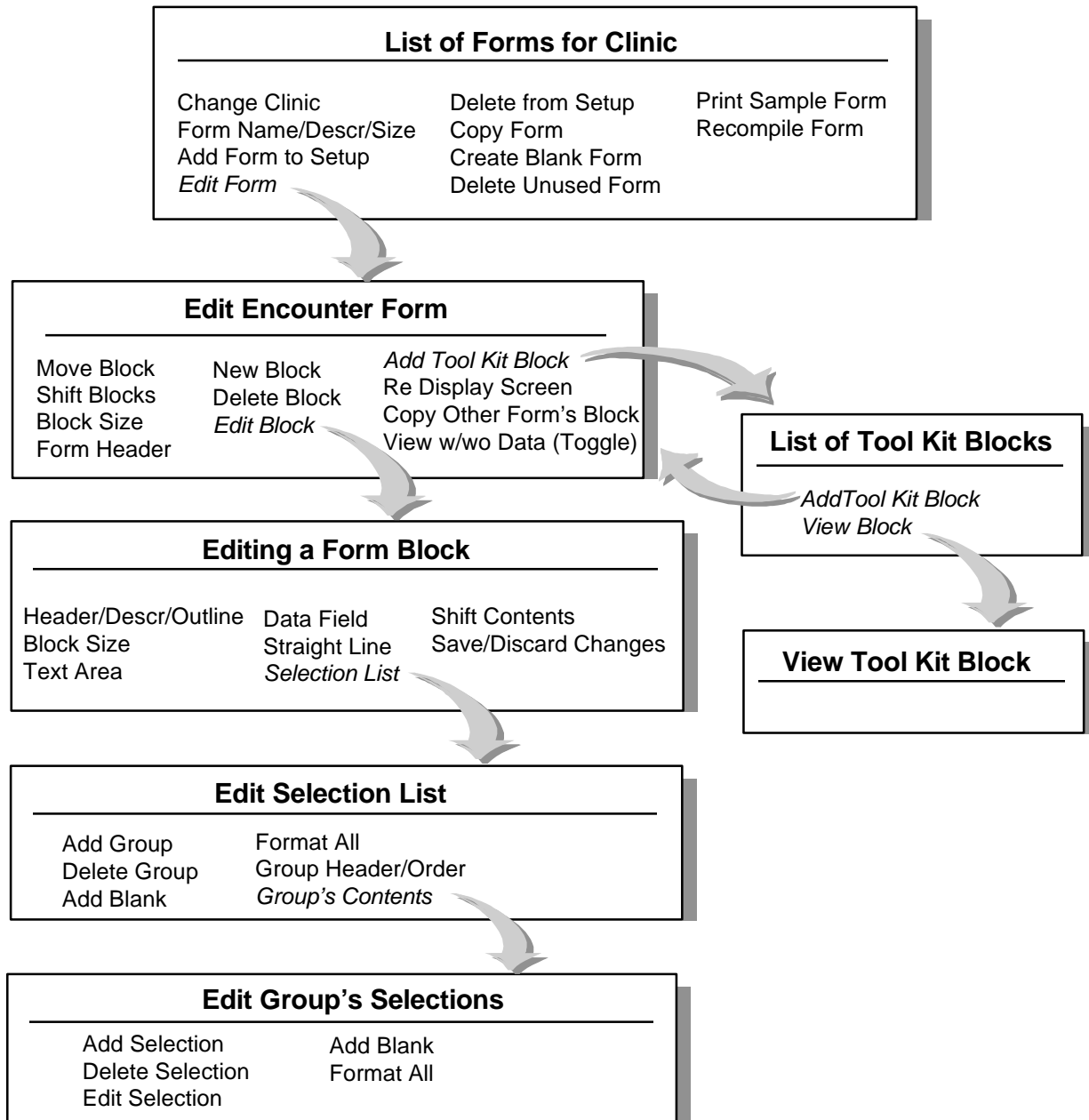
## II. NEW OPTIONS

### **Clinic Setup/Edit Forms** [IBDF CLINIC SETUP/EDIT FORMS]

This option allows you to assign encounter forms to clinics and to edit encounter forms. A description of the screens and actions accessible from this option follows.

The following chart shows each of the seven input screens. The screen title is shown at the top, followed by actions that may be performed. (Actions are not necessarily shown in the order in which they appear on your screen.) Actions shown in *italics* allow entry to other screens, indicated by the arrows.

## II. NEW OPTIONS, CONT.

**Clinic Setup/Edit Forms, cont.**

## II. NEW OPTIONS, CONT.

### **Clinic Setup/Edit Forms, cont.**

#### ***List of Forms for Clinic Screen***

Once a clinic is selected, the List of Forms for Clinic screen is displayed showing all forms currently assigned to the selected clinic, their use, and a brief description. Some of the functions available on this screen are assign forms to a clinic (encounter forms may be shared between clinics), edit, copy, and print forms. This screen also provides entry, through the Edit Form action, to the Edit Encounter Form Screen.

#### **Actions**

Change Clinic - This action allows you to select another clinic without exiting the option.

Form Name/Descr/Size - This action allows a form's name, description, and size to be edited.

Add Form to Setup - This action allows a form to be assigned to the selected clinic.

Delete from Setup - This action allows a form to be dropped from use for the selected clinic.

Copy Form - This action allows any form to be copied, renamed, and assigned to a clinic. To help you to create customized forms, a Tool Kit is provided which contains template forms and blocks that may be copied and edited to create new forms/blocks.

Create Blank Form - This action is used to create forms from scratch.

Delete Unused Form - This action allows a form that is not in use by any clinic to be deleted completely.

Edit Form (accesses Edit Encounter Form screen) - This action allows you to view a form and edit its appearance and content.

Print Sample Form - This action is used to print a form without patient data.

Recompile Form - This action, which allows forms to be recompiled, is a safety feature that will rarely, if ever, be used. Forms are automatically recompiled each time they are edited.

## II. NEW OPTIONS, CONT.

### **Clinic Setup/Edit Forms, cont.**

#### ***Edit Encounter Form Screen***

This screen is accessed through the *Edit Form* action on the List of Forms for Clinic screen. The Edit Encounter Form screen will display the selected form for editing.

#### **Actions**

Move Block - This action allows a block to be selected and moved anywhere on the form. The top left-hand corner is used as the reference point for moving the block.

Shift Blocks - This action allows you to shift a range of blocks up, down, or to either side.

Block Size - This action allows the size of the block to be changed, within the limits set by the size of the form. When sizing the block, you are asked to what line the bottom margin should be moved and to what column the right-hand margin should be moved.

Form Header - This action allows a sequence of header lines to be entered. A block is created and the header lines are automatically centered within the block in the sequence in which they are typed.

Add Tool Kit Block (accesses List of Tool Kit Blocks screen) - This action allows a Tool Kit block to be selected and pastes it to the desired position on the form. The block header, description, and size can be edited.

New Block - This action is used to create a new, empty block.

Edit Block (accesses Editing a Form Block screen) - This action allows a block to be selected and its appearance and contents to be edited.

Delete Block - This action allows a block to be selected for deletion. Everything in the block is also deleted.

Re Display Screen - This action redraws the entire form if you suspect the screen display of the form is not correct.

Copy Other Form's Block - This action is used to copy a block from any form into the one you're editing.

## II. NEW OPTIONS, CONT.

### **Clinic Setup/Edit Forms, cont.**

#### ***Edit Encounter Form Screen, cont.***

View w/wo Data (Toggle) - This action allows the user to select a patient and fills in the form with data for that patient.

#### ***List of Tool Kit Blocks Screen***

This screen is accessed through the *Add Tool Kit Block* action on the Edit Encounter Form screen. To help you to create customized forms, a Tool Kit is provided which contains template forms and blocks that may be copied and edited to create new forms/blocks. This screen displays a list of the available Tool Kit blocks for selection.

#### **Actions**

View Block (accesses View Tool Kit Block screen) - This action allows you to select Tool Kit blocks from the displayed list for viewing only.

Add Tool Kit Block (accesses Edit Encounter Form screen) - This action allows you to select Tool Kit blocks from the displayed list and edit the blocks placement and size (block's starting row, starting column, how many characters wide, how many lines high). Although you access the Edit Encounter Form screen, no actions are available for selection.

#### ***View Tool Kit Block Screen***

This screen is accessed through the Select Tool Kit Block action on the List of Tool Kit Block screen. It is for viewing only.

#### ***Editing a Form Block Screen***

This screen is accessed through the *Edit Block* action on the Edit Encounter Form screen. The block is displayed as nearly as possible to how it will appear on paper. You may edit the block's contents, appearance, and description.

#### **Actions**

Header/Descr/Outline - This action allows the block header and description to be edited. The outline of the block can be made invisible, or made to appear as a solid line.

Block Size - This action is used to change the size of the block.

## II. NEW OPTIONS, CONT.

### **Clinic Setup/Edit Forms, cont.**

#### ***Editing a Form Block Screen, cont.***

Selection List (\*Edit Selection List screen) - Lists of diagnoses, procedures, problems, etc. that can be included on each encounter form. The appearance of the selection list can be changed or deleted, a new selection list can be created, or the list's contents can be altered.

Data Field - Certain patient or clinic specific information may be automatically printed on the encounter forms. This action allows adding, editing, and deleting of these fields and their associated labels from blocks. Some data fields may have more than one data element (called subfields), such as SC Conditions, which has a name and a percentage. If the data field is a multiple, the ITEM NUMBER will specify the order and number limit that can appear on the form.

Straight Line - This action allows lines, either horizontal or vertical, to be added to the block, deleted, or edited.

Text Area - This action allows text areas to be added, deleted, or edited. A text area is the area within the block that contains text. The text is automatically formatted to fit within the defined area.

Shift Contents - This action allows you to shift the position of the contents of the block. The direction and degree of movement can be specified, as well as the type of object to be shifted and a range within which to act.

Save/Discard Changes - This action allows you to save or discard changes that you've made to a block. When you save changes, only the most recent copy is kept. If you discard changes, any changes you've made since the last save are discarded.

#### ***Edit Selection List Screen***

This screen is accessed by choosing to edit a list's contents through the *Selection List* action on the Editing a Form Block screen. It displays the selection groups defined for the selection list, with the header text and the print orders, and allows you to edit the contents of the list. A selection group is a group of selections with a header and a defined print order. A selection list is made up of one or more selection groups. To edit individual selections, a group must be selected. A group is a named collection of items on the list.

\*Choosing to edit the list's contents takes you to the Edit Selection List screen.

## II. NEW OPTIONS, CONT.

### **Clinic Setup/Edit Forms, cont.**

#### ***Edit Selection List Screen, cont.***

##### **Actions**

Add Group - This action allows a new group to be added. The header text and print order must be entered. A group named BLANK is special in that its header alone will not display to the form (i.e., its selections will be grouped together but won't appear under a header).

Delete Group - A group can be selected for deletion from the form. All of the group's selections are also deleted.

Group's Contents (accesses Edit Group's Selections screen) - This action allows the contents of the group to be edited.

Group Header/Order - This action allows the header text and print order to be edited.

Add Blank - This action allows the user to add a blank entry between other groups.

Format All - This action allows the user to format all of the selections on the list. For example, the text can be changed to all lower case.

#### ***Edit Group's Selections Screen***

This screen is accessed through the *Group's Contents* action on the Edit Selection List screen. It displays the selections appearing under the group, showing the text appearing on the form and the print order of the selections within the group. It allows you to edit selections on the list. A selection is just one item on the list, usually selected from a table, such as the table of ICD-9 Diagnosis Codes.

##### **Actions**

Add Selection - This action allows a new selection to be added to the group.

Delete Selection - This action allows a selection to be deleted.

Edit Selection - This action allows the text appearing on the form to be edited and the print order changed.



## II. NEW OPTIONS, CONT.

### **Clinic Setup/Edit Forms, cont.**

#### ***Edit Group's Selections Screen, cont.***

Add Blank - This action allows the user to add a blank entry between other selections in the group.

Format All - This action allows the user to format all of the selections in the group. For example, the text can be changed to all lower case.

#### **Copy CPT Check-off Sheet to Encounter Form** [IBDF COPY CPTs TO FORM]

This option asks you to select a CPT Check-off Sheet and Encounter Form. The Check-off Sheet's CPT codes are then copied to the Encounter Form.

#### **Define Available Report (not Health Summaries)** [IBDF DEFINE AVAILABLE REPORT]

This option is used to make reports (other than Health Summaries) available for use by the Print Manager. You are asked to enter the entry point in the program that prints the report and are allowed to specify entry and exit actions, required variables, etc. This option is meant for use by a programmer.

#### **Define Available Health Summary** [IBDF DEFINE AVLABLE HLTH SMRY]

This option allows a Health Summary to be made available for use by the Print Manager. The Health Summary must have already been created through the Health Summary package. This option can be used by the non-programmer.

#### **Miscellaneous Cleanup** [IBDF MISCELLANEOUS CLEANUP]

This option can be used to delete form blocks and compiled forms that are no longer in use. The utilities do this automatically, so this option will be used very rarely, if ever.

#### **Edit Clinic Reports** [IBDF EDIT CLINIC REPORTS]

This option is used to select encounter forms and reports that should print for the clinic. It can also be used to specify reports that should not print. This will override what is defined to print for the division.

#### **Edit Division Reports** [IBDF EDIT DIVISION REPORTS]

This option is used to select reports that should print for the entire division. Print conditions can be specified.

## II. NEW OPTIONS, CONT.

### **Edit Encounter Forms menu** [IBDF EDIT ENCOUNTER FORMS]

This menu contains the options that can be used to edit encounter forms other than those in the Tool Kit.

### **Edit Marking Area (for selection lists)** [IBDF EDIT MARKING AREA]

This option can be used by the local sites to create their own Marking Areas to supplement those that come with the Tool Kit. Marking Areas are the areas on a selection list that are marked to indicate choices.

### **Edit Package Interface** [IBDF EDIT PACKAGE INTERFACE]

This option allows package interfaces for selection routines and output routines to be created and edited. By creating their own package interfaces, the local sites can display data that is not provided in the Tool Kit to their forms. Care must be taken not to delete package interfaces that are in use.

### **Edit Tool Kit menu** [IBDF EDIT TOOL KIT]

This menu contains the options that allow you to edit forms and blocks contained in the Tool Kit.

### **Edit Tool Kit Blocks** [IBDF EDIT TOOL KIT BLOCKS]

This option is used to edit, create, and delete Tool Kit blocks. Following is a description of the screens and actions accessible through this option.

#### ***Edit Tool Kit Blocks Screen***

This screen displays a list of all the Tool Kit blocks. You are allowed to edit, create, and delete Tool Kit blocks.

#### **Actions**

Edit Block - This action can be used to select a block from the list and edit it. It takes you to the Edit Block screen, which is described under the Clinic Setup/Edit Forms option.

New Block - This action is used to create a new empty block.

Delete Block - This action is used to delete a Tool Kit block.

Copy Block - This action is used to copy a block from any form and make it a Tool Kit block.

Change TK Order - This action allows you to change the order of the Tool Kit blocks on the list.

## II. NEW OPTIONS, CONT.

### **Edit Tool Kit Forms** [IBDF EDIT TOOL KIT FORMS]

This option allows Tool Kit forms to be edited, created, and deleted. The screens and actions that are accessible from this option follow.

#### **List of Tool Kit Forms Screen**

This screen displays a list of all the Tool Kit forms. Tool kit forms can be created, edited, and deleted.

#### **Actions**

Form Name/Descr/Size - This action allows you to edit the name of the form, its description, and size.

Delete Form - This action is used to delete a form from the Tool Kit.

Copy Form - This action is used to copy any form and make it part of the Tool Kit.

Create Blank Form - This action is used to create a new form for the Tool Kit from scratch.

Edit Form - This action takes you to the Edit Form screen, which is described under the Clinic Setup/Edit Form option.

Print Sample Form - This is used to print any encounter form without patient data.

### **Encounter Form IRM Options** [IBDF IRM OPTIONS]

This menu contains the options that should only be available to MUMPS programmers.

### **Encounter Forms menu** [IBDF ENCOUNTER FORM]

This menu contains all of the Encounter Form Utilities options.

### **List Clinics Using Forms** [IBDF LIST CLINICS USING FORMS]

For each encounter form, this report lists the clinics using it.

### **Import/Export Utility** [IBDF IMPORT/EXPORT UTILITY]

This option allows forms and blocks to be transferred between sites. It utilizes a set of files in the 358 number range that serve as a workspace. To export, it invokes ^DIFROM; to import, it executes the Inits received from the other site. ^DIFROM is used only to affect the workspace. You can move forms into and out of the workspace. Following are the screens and actions that are accessible from this option.

## II. NEW OPTIONS, CONT.

### **Import/Export Utility, cont.**

#### ***Import/Export Workspace Screen***

This screen displays a list of the forms and Tool Kit blocks that are in the workspace. The workspace serves as a staging area where material can be either imported or exported.

#### **Actions**

Help - This action provides a description and step-by-step instructions of the import/export process.

List Tool Kit Blocks - These two actions are used to toggle back and forth between the display of the forms in the workspace and the Tool Kit blocks in the workspace.

Import Entry - This action is used to select a form or Tool Kit block from the workspace and make it into a real form or Tool Kit block that can be used at your site.

Delete Entry - This action is used to delete a form or Tool Kit block from the workspace.

Add Entry - This action is used to select a form or block and bring it into the workspace. Blocks selected are always made into Tool Kit blocks.

View Imp/Exp Notes - When exporting a form or block, a description of the exported object should always be included. This action allows the description to be viewed.

Edit Imp/Exp Notes - This action allows notes to be added and edited for each entry in the workspace. The notes are meant for the receiving site when exporting forms.

DIFROM - This action executes ^DIFROM, using a package entry that was created for use by the Import/Export Utility. It creates Inits for all the entries in the workspace.

Run Inits - This action executes the Inits, usually named ^IBDEINIT, received from another site and produced using the Import/Export Utility. Executing the Inits fills the workspace, but does not actually result in forms or blocks that can be used. The workspace only serves as a staging area from which forms can be imported or exported.

## II. NEW OPTIONS, CONT.

### **Import/Export Utility, cont.**

#### ***Import/Export Workspace Screen, cont.***

Clear Work Space - This action clears the workspace.

#### **Print Blank Encounter Form** [IBDF PRINT BLNK ENCOUNTER FORM]

This option allows you to select a clinic and print an encounter form that is defined to print without patient data for that clinic.

#### **Print Encounter Forms for Appointments** [IBDF PRINT ENCOUNTER FORMS]

This option is the principal means of printing encounter forms. You are asked to specify appointments for a particular date either by division, clinic, or patient. For each appointment, the encounter forms specified in the clinic setup are printed complete with patient data. The reports specified for the clinic and division are also printed. Sorting is either by division/terminal digits or by division/clinic/patient. The option allows you to specify that only add-ons should be printed. It also allows you to specify that printing should begin somewhere in the middle of the job, which is useful if a job terminates part of the way through due to equipment failure.

#### **Print Form w/Patient Data, No Appt** [IBDF PRNT FORM W/DATA NO APPT]

This option allows an encounter form to be printed with patient data, but does not ask that an appointment be selected. It uses the current time as the appointment time. You are allowed to either choose the form to print or to invoke the Print Manager.

#### **Print Manager menu** [IBDF PRINT MANAGER]

This menu contains all of the options pertaining to the Print Manager. The Print Manager is used to specify which encounter forms and reports should print for which clinics and divisions.

#### **Print Options menu** [IBDF PRINT OPTIONS]

This menu contains all of the options for printing encounter forms.

#### **Report Clinic Setups** [IBDF REPORT CLINIC SETUPS]

This option reports on each clinic setup, listing the encounter forms and other reports defined for use by the clinic.

### III. IMPLEMENTATION GUIDELINES

The purpose of these Implementation Guidelines is to provide a general format for the process of implementing the Encounter Form at your facility. Forethought and a study of the needs in your outpatient clinical areas are key ingredients to successful setup and use of this module's functionality. Descriptions of computer and non-computer-related steps one should consider are included in this portion. This guide is intended as a general overview of the implementation process and is not meant as a literal mandate in regard to steps taken.

#### **General Steps for Implementing**

1. *Begin by forming a committee.* It may be a good idea to include a member or two from each of the clinical services whose members attend clinics, as well as the Chief of Ambulatory Care, MAS, clinic supervisor, or designee. Physician participation and input is important, as it will affect acceptability by clinicians. Educate members of the committee regarding the module's capabilities and the end results (examples of encounter forms). Ask each clinical member to educate fellow clinicians about the Encounter Form, including the input needed from clinicians regarding the set-up and the following consequent benefits.

- Improved communications between clinician and administration
- Tailored forms which will provide administrative and clinical data needed by clinician
- Increased efficiency for progress notes and DHCP entry of CPT codes and Diagnoses
- Functionality in conjunction with the Problem List clinical DHCP package

Administrative members can educate peers or subordinates about their role in the use of Encounter Forms as well.

2. *Create an Implementation Plan.* The plan need not be a formal paper or study. Outline each of the individual tasks which need to be completed in the necessary order. It may be a good idea to have a number of committee members involved in the completion of these steps. Gain consensus and approval of Clinical, Administrative, and Executive Management. If steps are documented, they can be followed step by step and checked off.
3. *Execute the Implementation Plan.* The following is a sample of general tasks.
  - a. Create one or two general encounter forms for examples and for clinician review. You may also copy and/or print the forms in the Tool Kit as a beginning. Another alternative is to get copies from other facilities who have

already created forms. Forms can be imported and exported via the utility option in the Encounter Form IRM Options Menu.

### III. IMPLEMENTATION GUIDELINES, CONT.

#### **General Steps for Implementing, cont.**

- b. Organize appointments with clinicians for their input. Collect all needed data for the forms as explained below. It may be wise to interview all members according to their particular subspecialty, such as Dermatology or General Surgery. Standardize the questions you will ask, such as
  - (1) What kind of administrative information do you need, i.e., a list of SC disabilities? (An example of administrative data displayed by a Tool Kit form may be all they require here.)
  - (2) What particular diagnoses do you treat in your clinic? It is suggested that a list of diagnoses or a small ICD-9 code book be available during this portion of the interview to aid in pinpointing specific diagnoses.
  - (3) What particular treatment do you provide (in the form of CPT Codes)? Again, a CPT code list or book may help. It is strongly suggested that you run the option Most Commonly used Outpatient CPT Codes [IB OUTPUT MOST COMMON OPT CPT] for the clinics in question. The output will provide a list of CPT codes entered for each clinic for a user-specified date range. This will be very useful in identifying those CPT codes which should be listed on the form for the clinic. If your site has utilized the CPT Check-Off Sheets included in Integrated Billing version 1.5, you may use the option Copy CPT Check-off Sheet to Encounter Form [IBDF COPY CPTS TO FORM], which will allow you to copy all CPT information on a Check-Off sheet and upload it to a CPT code graphics box previously placed into the form. CPT codes should be updated in all of the Check-Off Sheets first by using the Delete/List Inactive Codes on Check-off Sheets [IB BASIC INACTIVE CODES] option (in the Ambulatory Surgery Maintenance Menu) before uploading to the Encounter Form. This step will save considerable time and effort.
- c. Create forms for clinicians and give them copies to review. Make any necessary changes. You may also wish to create versions of the form with an area for imprinting the patient's data card with the embosser. Tip: Copy the clinic's basic form and modify the copy to include the space for the card imprint. The area for the ID Card imprint is included as a Tool Kit block. You may also get copies from other facilities who have already created forms. As mentioned before, forms can be imported and exported via the utility option in the Encounter Form IRM Options Menu.



### III. IMPLEMENTATION GUIDELINES, CONT.

#### **General Steps for Implementing, cont.**

- d. Identify Health Summary reports used by your clinicians. You will be able to identify them for the Print Manager functionality by using the Define Available Health Summary [IBDF DEFINE AVLABLE HLTH SMRY] option and then include them in the printout setup by using either of the Edit Division Reports [IBDF EDIT DIVISION REPORTS] (regarding a default Health Summary for the division) or the Edit Clinic Reports [IBDF EDIT CLINIC REPORTS] option (to set Health Summaries for specific clinics.)
4. *Implement Form Usage.* It may be a good idea to introduce the Encounter Forms for a portion of your clinics at one time. For example, a site could first implement forms for all surgical clinics at one location. There are a number of issues to decide upon before actually printing the forms.
    - a. Where will the forms be printed and how will they be distributed? Your committee members must decide if they will be printed at night in one location and how they will be distributed. It may be feasible to have them print near the site's file room. Due to the availability of the Print Manager functionality, your site can designate other forms (such as the Routing Slip, Pharmacy Action, or Information Profile) and any identified Health Summary reports to print in terminal digit or alphabetical (clinic then patient) order. This way, the printouts can easily be integrated with patient record pull lists and attached to the patient's record during the chart pull process.
    - b. After Encounter Forms are filled out by the clinician and used by the clerk to input information, where do they go? Your committee should decide whether to include them in the patient's chart, send to billing, etc. Input from MAS and MCCR is necessary at this step.
    - c. Data Validation considerations. Will your facility implement a "checks & balances" function to insure information from the sheet is entered correctly in the system? You may wish to include the Appointment Status Tool Kit block on your forms as part of this requirement. Clerks can then check off whether the appointment was rescheduled, cancelled, no-showed, or checked out.
    - d. Training. How will you train involved personnel in the use of the Encounter Form? Also, training for different users may be a good idea. An example is an involved clinician providing a training session to other clinicians on the use of and need for the Encounter Form.

### III. IMPLEMENTATION GUIDELINES, CONT.

#### **General Steps for Implementing, cont.**

- e. "Local" Customs. Local conventions on the use of the form should be decided upon. For example, how will the clerks identify a no-show or a canceled appointment on the form?
  - f. Non-compliance. Who will address lack of use of the form (if this is an issue)? How will it be handled? Will a clinical manager, such as the Chief of Staff or clinical service chief, become involved? Approval and endorsement from hospital management will lower the likelihood of problems.
5. *Monitor the process and make improvements where you find problems.* Keep the committee intact and informed until the process has been completed and is running smoothly at the facility.

### IV. GENERAL COMMENTS

#### **Getting Started**

There are steps that the local site must take before encounter forms can be used.

First, forms must be designed and assigned to the clinics. Forms can be shared between clinics, but it is important to control who has responsibility for editing the shared forms. One important aspect of designing encounter forms is determining what codes should go on the form. Many encounter forms will have lists of CPT codes, diagnosis codes, or problems. Because space on an encounter form is at a premium, careful analysis is required to determine the codes most commonly used by the clinic before entering codes to the form. For CPT codes, the option Most Commonly Used Outpatient CPT Codes [IB OUTPUT MOST COMMON OPT CPT] can be used to determine a clinic's most commonly used codes.

Procedures for printing the encounter forms must be determined. Some of the questions that must be answered are what printers to use, can the printers be loaded with enough paper, how many days in advance should the forms be printed, what time of day to run the print job, should the printers be watched, and what to do if there are printer problems. It is expected that most printing of forms will be done in batch at night for entire divisions, and that forms will be printed several days in advance with only the add-ons printed the night before.

#### IV. GENERAL COMMENTS, CONT.

Then there are questions concerning what to do with the encounter forms - how will the completed encounter forms be routed, who will input the data, etc. It is expected that much of the collected data will be input through checkout which is part of PIMS v5.3.

The Print Manager that comes with the Encounter Form Utilities is expected to be very useful to the local sites. Sites must decide which reports should be printed. The Print Manager allows these reports to be specified along with the encounter forms. The fastest way to define the reports is at the division level, rather than at the clinic level. Individual clinics can override reports defined to print at the division level.

#### **Printer Considerations**

##### Lines Per Inch, Characters Per Line

It is highly recommended that each site standardize on the number of lines per page and the number of characters per line that all encounter forms will use. This recommendation is made because different kinds of forms may be printed for a single print job and also because the print job could cover multiple clinics. Since only one device may be selected each time the option is used, unless all forms printed are defined to have the same number of lines per page and characters per line, some of the forms will be printed improperly. During development of the utilities, 80 lines per page with 132 characters per line was found to be a good choice. Another reason that 132 characters per line is a good choice is that some of the reports that can be printed through the Print Manager require it.

##### Boxes

The utilities allow boxes to be drawn around blocks. Defining these terminal attributes will improve the appearance of the boxes drawn.

```

XY CRT
TOP LEFT CORNER
BOTTOM LEFT CORNER
TOP RIGHT CORNER
BOTTOM RIGHT CORNER
VERTICAL LINE
HORIZONTAL LINE
GRAPHICS OFF
GRAPHICS ON

```

NOTE: Boxes printed with a gap between each vertical line are an indication that either the lines per inch or the font point size should be increased.

#### IV. GENERAL COMMENTS, CONT.

##### Underlining

The utilities have the ability to underline text. The following terminal attributes might be used if defined.

UNDERLINE ON  
UNDERLINE OFF

##### Emboldening

The utilities have the ability to embolden text if the following terminal attributes are defined.

HIGH INTENSITY (BOLD)  
NORMAL INTENSITY (RESET)

NOTE: On the HP LaserJet IIISi that the utilities were developed on, emboldening did not work using the terminal setup shown at the end of this section! This was due to no bold font being available that had all of the other requested characteristics.

##### Example Terminal Setup for a HP LaserJet IVSi printer

XY CRT	W \$C(27)_"@a"_DX_"C"_\$C(27)_"@a"_DY_"R"
FORM FEED	#
PAGE LENGTH	80
BACK SPACE	\$C(8)
OPEN EXECUTE	W \$C(27),"E",\$C(27),"(s16.7H",*27,"&l8D"
CLOSE EXECUTE	W \$C(27),"E"
UNDERLINE ON	\$C(27)_"&dD"
UNDERLINE OFF	\$C(27)_"&d@"
HIGH INTENSITY (BOLD)	\$C(27)_"(s3B"
RIGHT MARGIN	132
NORMAL INTENSITY (RESET)	\$C(27)_"(s0B"
GRAPHICS ON	\$C(27)_"(10U"
GRAPHICS OFF	\$C(27)_"(8U"
TOP LEFT CORNER	\$C(218)
BOTTOM LEFT CORNER	\$C(192)
TOP RIGHT CORNER	\$C(191)
BOTTOM RIGHT CORNER	\$C(217)
VERTICAL LINE	\$C(179)
HORIZONTAL LINE	\$C(196)

Albany ISC  
Troy, NY

**Form Header - occupies a block. In this example, it has an invisible outline.**

**Block - with a solid outline and no block header.**

**Contains Data Fields.**

**Label >>**

**Data >>**

Patient Name: MOORE,JEFFERY	
DOB: JAN 1,1945	PID: 535-76-3235
SC Conditions:	
OSTEOMYELITIS	10%

**<< Data field with two subfields**

**Subcolumn containing a Marking Area**

**Subcolumn Headers >>**

**Group Header >>**

**Group's Selections >>**

**Subcolumn containing TEXT >>**

VISIT (mark one only)		CODE	X
NEW PATIENT			
Brief Exam	(1-10 min)	90000	
Limited Exam	(11-20 min)	90010	
Intermediate Exam	(21-30 min)	90015	
Extended Exam	(31-45 min)	90017	
Comprehensive Exam	(46-60+ min)	90020	
ESTABLISHED PATIENT			
Brief Exam	(11-20 min)	90040	
Limited Exam	(11-20 min)	90050	
Intermediate Exam	(21-30 min)	90060	
Extended Exam	(31-45 min)	90070	
Comprehensive Exam	(46-60+ min)	90080	

**Selection List - contains one column of selections. The column has three subcolumns.**

**Block Header - centered and underlined>>**

**This Selection List has two columns. Each column has three subcolumns.**

PLEASE CHECK OFF CPT CODES THAT APPLY					
CODE	PROCEDURE	X	CODE	PROCEDURE	X

**Block Header - underlined, not centered >>**

**Form Lines - (Horizontal & Vertical)>>**

**Text Area >>**

TEST SAMPLE BLOCK	
	<p>RELEASE OF INFORMATION: I authorize any holder of medical information about me to release to the Health Care Financing Administration (Medicare), and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize any holder of medical information about me to release to any insurance company .....</p>

## Section 3. Insurance Data Capture

### I. FUNCTIONAL DESCRIPTION

For several years, there have been a number of requests for enhancements to Insurance Data Capture. To accomplish this, conceptual changes in the way insurance data is captured and stored were needed. Changes have been made to the insurance data stored in the PATIENT file (#2). Specifically, data elements which are related to an insurance group plan have been moved. This data may be shared by many patients. (An example of a group plan is the General Motors Retirees plan. All retirees of GM get the same coverage.)

Users have asked for the ability to store more detailed information about insurance companies, group plans, and benefits. IB v2.0 provides at least five new files to store this data, and many new fields in the PATIENT file (#2) and the INSURANCE COMPANY file (#36). There is no requirement that this information be added.

The data input for Screen 5 of Registration and Load Edit has been streamlined with this release. There are stand-alone options to update the insurance company and patient insurance information. There are "view only" options that mirror the data input options. Additionally, there are tools provided to help clean up files containing duplicate and/or inactive insurance companies.

This module is radically different from what you now have. Currently, you have two main components to insurance information, insurance company information and patient policy information. IB v2.0 will have five main components to insurance information. You will still have insurance company information which is greatly enhanced and will be discussed later. We are dividing the current patient policy information into two components. We are leaving the information specific to the patient's policy in the PATIENT file (#2), but we are moving information specific to the group plan to a new file. This then allows us to add the two new components, Annual Benefits and Benefits Used.

Many patients have identical policies providing identical benefits from the same group plan. The goal was to input this data once, then utilize it for all patients who belong to the same group plan.

Future releases of IB will include enhancements to the Insurance Data Capture module. The goal is that once this information is known, it can be used to accurately estimate the dollar amount that you can expect to receive for any episode of care. If you know the type of care and compute the billing charges, the benefits available, and the benefits used to date, you can attempt to compute what you

## I. FUNCTIONAL DESCRIPTION, CONT.

should receive. This will tie in closely to the Claims Tracking module, also released in IB v2.0.

### **Insurance Company Changes**

There is a great deal of new functionality in the Insurance Company module. First there is a new Insurance Company Entry/Edit option. You will use this option to enter and store all of the addresses and phone numbers used by an insurance company: addresses for inpatient claims, outpatient claims, appeals, pre-certifications, and inquiries. In addition, it is possible to specify that one company performs functions (such as pre-certifications or outpatient claims) for another company. The addresses supplied here are then automatically used in the Billing module. If you do not enter data in these special address fields, bills will continue to use the original "main" address of the company performing the function. Additionally, both a comments field and a field for synonyms (alternative names for the same insurance carrier) have been added to the INSURANCE COMPANY file (#36).

IB v2.0 provides you with tools to manage duplicate entries in your INSURANCE COMPANY file (#36). There is a new report that shows patients with policies associated with INACTIVE insurance companies. You may use the new Insurance Company Entry/Edit option to inactivate insurance companies (provided you hold a new key, IB INSURANCE SUPERVISOR). One reason to inactivate an insurance company is that it is already in the INSURANCE COMPANY file (#36), but under a synonym. When inactivating a company, you may print a list of its patients and (optionally) merge these patients to a new company. Because the new data structures are complex, the whole thing is done automatically for you. You may also specify synonyms for insurance companies. With these two tools, you should be able to inactivate duplicate-named companies and reduce potential new duplicates, as well as clean up old problems.

Unwanted insurance company entries should be inactivated rather than deleted. It will not be possible to delete an insurance company unless you are a holder of the new key, IB INSURANCE SUPERVISOR, and all patients with policies with this company have been merged to another company. Because of the new MCCR NDB reports, it is important to keep old entries that have claims associated with them as this may be reported nationally.

### **Patient Insurance Policy and Renewal Data Changes**

The agent information currently stored in the PATIENT file (#2) has been flagged as obsolete, as well as the GROUP NAME and GROUP NUMBER fields in the PATIENT file (#2), which have moved to the new GROUP INSURANCE PLAN file (#355.3). A separate message is being sent as formal notification to the IRM

## I. FUNCTIONAL DESCRIPTION, CONT.

services. If you currently use any data in these fields and anticipate continued need, you will need to work with your local IRM to make sure they save this data.

There is a lot of new functionality being added to the patient policy information. The system now automatically captures the user name and date the information is entered and last edited. There is a separate action to verify insurance data and record the date and the user performing the verification. A field has been added to indicate if the policy is the primary, secondary, or tertiary policy for this patient. The ability to specify that the policy should be sent to the patient's employer is included. Users may enter the specific address where the bill should be sent for those patients whose employers pre-process claims for the insurance carrier. Deleting policies will not be allowed if the patient has any uncanceled bills associated with the same insurance company.

One of the major new components is the addition of a mail message that is sent every time a new policy is added for a patient who has current or previous episodes of care (in the past two years) which may be billable. The mail message will list the policy added, any previous policies, what is potentially billable (inpatient and outpatient care), who added the policy, when it was added, and the option used. This is intended to allow billing for care when the policy is identified after the care was provided.

### **Group Plans**

It is important to differentiate Group Plans from the term "policy". Each patient policy will point to a Group Plan. If a patient has an individual plan, it may be selected in the system only for that patient. The new GROUP NUMBER and GROUP NAME fields will be stored under Group Plans. It is important to realize that editing this information may affect many more patients than just one. It is also possible to store whether pre-certification and Utilization Review are required for this plan. For each plan, you may indicate its type (e.g., Major Medical, Medicare, supplemental, etc.) whether the plan requires UR, and whether it requires pre-certification. This information is used by the Claims Tracking module also scheduled for release with IB v2.0.

The ability to add comments has been greatly expanded. Brief comments may be added about a policy in the PATIENT file (#2). Long comments may be added about the group plan that can then be seen when editing the policy information for all patients with that plan. Comments may also be added when calling for insurance verification of inpatient care along with updating fields about who was contacted, any pre-certification or authorization number, etc. This information is then available to the person doing MCCR/UR reviews.



## I. FUNCTIONAL DESCRIPTION, CONT.

### **Annual Benefits**

The ability to store the benefits that a plan covers by year has been added. The year will usually be a calendar year but it may start on any date. There are many fields to enter the amount or percent of coverage for specific types of care (inpatient, outpatient, mental health, substance abuse, etc.). Once this data is entered for a year, it will be available for all patients covered by the same group plan. This functionality will help those who have to call for insurance verification. There will be an up-front cost to gathering and storing this data. Once captured, however, it will be of great benefit. Entry of any or all information in this file is strictly a local decision.

### **Benefits Used**

As part of insurance verification, questions such as whether the patient has any remaining coverage for the type of care s/he is receiving in your medical center may be asked. This is especially true for Mental Health and Rehabilitative Services. A place is now provided to record this information. You may enter the benefits used, (e.g., has the patient met any applicable deductible), how much has been paid on an annual or lifetime maximum, etc. This information should be of great help when determining if the amount received from a carrier matches the expected receivable.

## II. CHANGED OPTIONS

### **Insurance Company Entry/Edit** [IBCN INSURANCE CO EDIT] (formerly Insurance Company Edit)

This option has changed both in functionality and appearance. The option now uses the List Manager screens as does much of Integrated Billing. The functionality has been expanded to handle a number of different addresses, to provide for synonyms and comments, and to add tools to merge companies. When editing an insurance company, the following actions are available.

#### **Actions**

Billing Parameters - This action allows editing of fields that are used by the Billing module.

## II. CHANGED OPTIONS, CONT.

### **Insurance Company Entry/Edit, cont.**

(In)Activate Company - This action allows you to inactivate an active company or activate an inactive company. When inactivating a company, a warning will be given if there are patients covered by this company. If so, you will be allowed to print a list of the patients and to repoint or merge the patients into another (active) insurance company entry. Use the new option List Inactive Ins. Co. Covering Patients [IBCN LIST INACTIVE INS W/PAT] to get a list of these companies. Then choose the action (In)Activate Company and accept the INACTIVE status. You can then list the patients and merge companies if you so choose. When patients are repointed, no plan or policy data from the inactive company entry is lost. Rather, this information is inherited by the insurance company entry to which the patients have been repointed.

Main Mailing Address - It is now possible to specify a number of new specific addresses for each insurance company. The old address fields are now referred to as the Main Mailing Address. This action allows editing of this address. Billing will automatically use the Main Mailing Address unless a separate address has been specified for claims, appeals, or inquiries.

Inpt Claims Office - This action allows you to specify a separate address and phone for inpatient claims. There are two ways to specify Inpatient Claims Addresses. First, you can specify that another company processes inpatient claims for the original company. If you specify the company, the Inpatient Claims Address or Main Mailing Address of the entry that is specified will be used. Alternatively, you can complete the address and phone number fields for a separate address for the original company.

Opt Claims Office - This action allows you to specify a separate address and phone for outpatient claims. There are two ways to specify Outpatient Claims Addresses. First, you can specify that another company processes outpatient claims for the original company. If you specify the company, the Outpatient Claims Address or Main Mailing Address of the entry that is specified will be used. Alternatively, you can complete the address and phone number fields for a separate address for the original company.

## II. CHANGED OPTIONS, CONT.

### **Insurance Company Entry/Edit, cont.**

Prescr Claims Of - This action allows you to specify a separate address and phone number for prescription claims. There are two ways to specify Prescription Claims Addresses. First, you can specify that another company processes prescription claims for the original company. If you specify the company, the Prescription Claims Address or Main Mailing Address of the entry that is specified will be used. Alternatively, you can complete the address and phone number fields for a separate address for the original company.

Appeals Office - This action allows you to specify a separate address and phone number for sending appeals. There are two ways to do this. They are analogous to the two ways to specify Claims Office Addresses. (Refer to Inpt Claims Office and/or Opt Claims Office actions.)

Inquiry Office - This action allows you to specify a separate address and phone for insurance verification. There are two ways to do this. They are analogous to the two ways to specify Claims Office Addresses. (Refer to Inpt Claims Office and/or Opt Claims Office actions.)

Remarks - This action allows you to add comments about the insurance company.

Synonyms - This action allows you to enter synonyms for the specified insurance company. Part of the problem with duplicate insurance companies is that previously there was no way to assign multiple names to the same company. For example, there are several common abbreviations for Blue Cross/Blue Shield (such as BCBS, BC/BS, BC-BS) all of which may appear as unique entries in your database, thus creating duplicates. When merging companies, make sure that you add the common synonyms so that it is easy for the personnel adding policies to retrieve the correct company.

Edit All - This action allows editing of all the fields in the INSURANCE COMPANY file (#36).

Change Insurance Co. - This action allows selecting a new insurance company to edit without having to leave the option.

### III. NEW OPTIONS

#### **Patient Insurance Menu** [IBCN INSURANCE MGMT MENU]

This menu contains the Insurance Company Entry/Edit [IBCN INSURANCE CO EDIT] option, the Patient Insurance Info View/Edit [IBCN PATIENT INSURANCE] option, two new reports, and two "view-only" options. It is designed as a supervisor's menu where all insurance-related options are logically located. Normally one or two of the edit or view options will be placed on menus for the necessary users.

#### **Patient Insurance Info View/Edit** [IBCN PATIENT INSURANCE]

This new option allows editing or viewing of all patient policy and plan information. It consists of one list screen and three display screens. Upon selecting a patient, you are given a list of the patient's policies and may take a number of actions on these. Three of the actions involve moving to the three display screens that in turn have their own set of actions that may be taken. There is the Expanded Policy View screen where you can add/edit the policy and plan information and view comments, user information, etc. There is the Annual Benefits screen where the benefits that are provided by the plan for a year can be entered. An annual benefit year may begin on any date. For any plan, there may be more than one annual benefit year, but they must all be at least one year apart. Finally, there is the Benefits Used screen where you can enter the benefits that a patient has used against a policy. There must be an annual benefit year for the corresponding plan entered on the Annual Benefits screen before you can enter the benefits used.

#### **Actions**

Add Policy - This action is used to add a new policy for the patient. A new plan can be created during this action or a previously created plan can be selected.

Delete Policy - This action is used to delete a patient's policy. A policy cannot be deleted if there is a bill for the specified insurance company on file for the selected patient. You must also hold the new key IB INSURANCE SUPERVISOR.

Annual Benefits - This action takes you to the Annual Benefits screen, which is a display/edit screen where a number of possible benefits may be entered.

Policy Edit/View - This action takes you to the Expanded View screen for the plan and policy. Information can be edited and viewed, including the addition of comments, user information, contacts, etc. not available on the Main List screen.

### III. NEW OPTIONS, CONT.

#### **Patient Insurance Info View/Edit, cont.**

Fast Edit All - This action allows you to quickly edit the most common information about a policy.

Benefits Used - This action takes you to the Benefits Used screen. This is a display/edit screen where a number of commonly used benefits can be entered for the patient for a specific policy/year.

Verify Coverage - This action allows you to flag the insurance policy as verified. This can be used in conjunction with the new option List New not Verified Policies [IBCN LIST NEW NOT VER] to ensure that a contact has been made with the insurance company to verify the insurance. The date and user name are automatically stored.

Personal Riders - This action allows you to edit personal riders.

Change Patient - This action allows you to select a new patient without exiting the option or action.

Worksheet Print - This action allows you to print a worksheet for collecting insurance information when contacting an insurance company.

Print Insurance Cov. - This action produces a report whose format is similar to that of Worksheet Print; however, it will print the past two years' coverage for the patient's policy.

#### ***Policy Edit/View Action Screen***

This screen displays policy and plan information for whichever of the patient's policies you selected.

#### **Actions**

Change Plan Info. - This action allows you to edit fields related to the Group Plan.

UR Info. - This action allows you to edit four group plan fields related to Utilization Review.

III. NEW OPTIONS, CONT.

**Patient Insurance Info View/Edit, cont.**

***Policy Edit/View Screen, cont.***

Effective Dates - This action allows you to edit the effective and expiration dates of the policy.

Subscriber Update - This action allows you to edit the subscriber information about the policy.

Insur. Contact Info. - This action allows you to enter the name of a contact with the insurance company. If the patient is a current inpatient, this will automatically create an Insurance Review in the Claims Tracking module that is linked to the admission. The information and comments will be available to the person performing the Insurance Review.

Employer Info. - This action allows you to specify that the employer pre-processes the claim for the carrier. You may enter an address where the claim should be sent. This address will automatically be used by the Billing module.

Add Comment - This action allows you to enter a brief comment about the patient's policy and an unlimited comment about the group plan.

Fast Edit All - This action allows you to edit all the information about the plan and policy.

Annual Benefits - This action takes you to the Annual Benefits screen. This is a display/edit screen where a number of possible benefits may be entered.

Benefits Used - This action takes you to the Benefits Used screen. This is a display/edit screen where a number of commonly used benefits can be entered for the patient for a specific policy/year.

Verify Coverage - This action allows you to flag the insurance policy as verified. This can be used in conjunction with the new option List New not Verified Policies [IBCN LIST NEW NOT VER] to ensure that a contact has been made with the insurance company to verify the insurance. The date and user name are automatically stored.

### III. NEW OPTIONS, CONT.

#### **Patient Insurance Info View/Edit, cont.**

##### ***Annual Benefits Screen***

This screen displays the benefits provided by a particular plan for the selected benefit year.

##### **Actions**

Policy Info - This action allows you to quickly edit general plan benefits.

Inpatient - This action allows you to edit inpatient benefits.

Outpatient - This action allows you to edit outpatient benefits.

Mental Health - This action allows you to edit mental health benefits.

Home Health - This action allows you to edit home health benefits.

Hospice - This action allows you to edit hospice benefits.

Rehab - This action allows you to edit Rehab Service benefits.

IV Mgmt. - This action allows you to edit IV management benefits.

Edit All - This action allows you to edit all benefit fields.

Change Year - This action allows you to edit the plan benefits for a different benefit year.

##### ***Benefits Used Action Screen***

This screen displays the benefits that a patient has used against one of the benefit years of one of their policies.

##### **Actions**

Policy Info - This action allows you to edit general benefits that have been used, such as whether the deductible been met for the year.

Opt Deductible - This action allows you to enter the outpatient benefits that have been used.

### III. NEW OPTIONS, CONT.

#### **Patient Insurance Info View/Edit, cont.**

##### ***Benefits Used Action Screen, cont.***

Inpt Deductible - This action allows you to enter the inpatient benefits that have been used.

Add Comment - This action allows you to enter comments about the benefits used.

Change Year - This action allows you to edit the benefits used for a different benefit year.

Edit All - This action allows you to edit all benefits used fields.

#### **List Inactive Ins. Co. Covering Patients** [IBCN LIST INACTIVE INS W/PAT]

This option will print a list of insurance companies that are currently inactive but still have patients with policies associated. This situation is created when duplicate-named insurance companies are inactivated. Use the (In)activate Company action available through the Insurance Company Entry/Edit [IBCN INSURANCE CO EDIT] option to list the patients by company and to merge them to another company if appropriate.

#### **List New not Verified Policies** [IBCN LIST NEW NOT VER]

This option will print a list of policies added in the selected date range which have not been verified in the past 365 days. Generally, this report is run to find policies added to a patient's record that have not been verified by the person assigned that responsibility. Because policies are generally identified by MAS during registration, this was designed to help sites identify cases added that may still need to have additional data collected.

#### **View Patient Insurance** [IBCN VIEW PATIENT INSURANCE]

This option is very similar to the Patient Insurance Info View/Edit [IBCN PATIENT INSURANCE] option; however, no editing of insurance data is allowed. This option can be assigned to users who need read access to this information but have no need to update the information.

#### **View Insurance Company** [IBCN VIEW INSURANCE CO]

This option is very similar to the Insurance Company Entry/Edit [IBCN INSURANCE CO EDIT] option; however, no editing of insurance company data is allowed. This option can be assigned to users who need read access to this information but have no need to update the information.



#### IV. IMPLEMENTATION GUIDELINES

There are a number of tools in the Insurance module to identify duplicate INSURANCE COMPANY file (#36) entries and to resolve these problems. It may also be helpful to review the process of how insurance information is collected at your facility. This module was designed so that as little information as possible would be collected during registration and that more complete information would be collected by a separate employee who would contact the insurance company.

##### **Prior to installation**

You may want to review how the GROUP NUMBER and GROUP NAME fields in the INSURANCE TYPE multiple of the PATIENT file (#2) are entered. These will be used to create the new GROUP INSURANCE PLAN file (#355.3). A new group plan will be created for every unique group plan entry for each insurance company. If possible, you may want to consolidate similar but unique names.

You may want to print a list of all active and inactive insurance companies along with their addresses. There are a number of new insurance company address fields. Determine which insurance company entries can be inactivated and merged into another (active) insurance company entry. (Note: Do not delete the old entries. They must be inactivated at this time.)

Determine which users should have access to the new Insurance options. There are options that allow for view-only access to both the insurance company information and patient insurance information as well as options for data entry. Limiting the ability of certain individuals to add/edit/delete information may improve the quality of your insurance information. Having accurate and detailed insurance information can improve your collections by focusing your efforts on cases that are potentially reimbursable.

Many sites enter Medicare and Medicaid policy information as an insurance policy. If the entry in the INSURANCE COMPANY file (#36) for Medicare and Medicaid exist, we recommend that the field WILL REIMBURSE? be answered "NO". This will prevent the software from treating this as a billable insurance company entry. If this is answered other than "NO", this could have a significant impact on the Claims Tracking module.

#### IV. IMPLEMENTATION GUIDELINES, CONT.

##### **After Installation**

First, run the option List Inactive Ins. Co. Covering Patients [IBCN LIST INACTIVE INS W/PAT]. This option will list companies that are currently covering patients who are non-billable due to the insurance company being inactive. In the Insurance Company Entry/Edit [IBCN INSURANCE CO EDIT] option, there is an action to activate and inactivate an insurance company. Use this action for the inactive insurance companies and it will allow you to print a list of the patients covered under this company. If you wish to merge the patients to another company, you may do so at this or a later time.

If you found in your list of insurance companies that you have many similar entries to handle different inpatient, outpatient, or prescription address information, you may want to combine these entries into one. Choose the entry you wish to update and enter the complete information. Then go back and inactivate the companies you no longer wish to use and use the feature that lets you merge (repoint) the patients to the updated company entry. If you found many similar entries with the same name but entered slightly differently, you may want to consider entering those names as synonyms for the updated company.

The option List New not Verified Policies [IBCN LIST NEW NOT VER] can be run periodically to list new policies that have been added since a specific date and have not been verified by your insurance staff. Updating this information can help you maintain the patient insurance information and allow your MCCR staff to concentrate on billing for covered care. This may foster good communication with your insurance carriers and ultimately improve your rates of collection.

#### V. NEW OR CHANGED MAIL MESSAGES

There is one new mail message in the Insurance module. A mail message is generated whenever a new billable insurance policy is added for a patient who has billable inpatient episodes or scheduled outpatient visits within the effective dates of the policy (going back to the beginning of the prior calendar year). The mail message lists the new policy, any other policies, potentially billable inpatient stays, and scheduled outpatient visits.

## VI. GENERAL COMMENTS

### **Programmer APIs**

A number of Programmer APIs are now available to retrieve insurance information and to display patients' policies. It is requested that developers not directly access insurance information, but rather use the provided interface calls so that we do not limit our future development plans. Specific information on using the programmer APIs can be found in the IB v2.0 Technical Manual.

### **General Information**

A new field, SOURCE OF INFORMATION (#1.09), has been added to the INSURANCE TYPE subfile of the PATIENT file (#2). If you are involved in a project to identify insurance from any other means than by conventional contact of the patient or the patient's employer (e.g., electronic requests for information), this field should be updated appropriately. The changes to the MCCR national data base will be using this information to determine the cost effectiveness of these and other initiatives.

The IBCN NEW INSURANCE EVENTS Event Driver has been added which is executed every time a new insurance policy is added for a patient. The IVM team will be using this event driver in the future. It was created to provide a single point to indicate where a new insurance policy has been added. It is used to trigger a mail message whenever a new policy is added that has current or past (two years) potentially billable care. Presently, it is not executed for edits or deletions. This could be done if requested.

We have at least one integration agreement to use calls in routine DGCRNS. This routine will continue to be exported and supported with IB v2.0 but will be discontinued with the first release 18 months after IB v2.0 is released. Developers can easily convert to the same functionality as it appears in routine IBCNS (almost exactly the same functionality, just moved to the IB namespace) or convert to the more reliable calls listed in the Callable Routines section of the Technical Manual. There is a logic problem with the calls to DGCRNS and IBCNS which return the insurance arrays that may cause a second policy with the same company to fail to be contained in the array or list.

## Section 4. Patient Billing

### I. FUNCTIONAL DESCRIPTION

The Integrated Billing Patient Billing module encompasses all software systems which generate charges which are directly billed to the patient. These systems currently include the Pharmacy Copay and the Automated Means Test Billing modules.

This release provides many enhancements to the Patient Billing module, focusing primarily on Means Test billing. Full integration is achieved with the checkout functionality in PIMS v5.3, incorporating legislative changes released over the past year which restrict billing for veterans who have claimed exposure to Agent Orange, Ionizing Radiation, and Environmental Contaminants. Additionally, outpatient encounters recorded in Scheduling as registrations or stand-alone stop codes are now billed automatically. The implementation of this functionality allows sites to flag specific stop codes, clinics, or dispositions which should not be billed.

The Cancel/Edit/Add Patient Charges [IB CANCEL/EDIT/ADD CHARGES] option has been reworked extensively. The user interface has been redesigned, the ordering of prompts has been improved, and new functionality has been introduced.

Many requests for improvements in the Means Test Billing module which have been received from the field have been incorporated into this release.

- The mail messages generated when patient movements or Means Test data is changed have been improved. These messages will now be generated only when Means Test charges might actually be affected. Additional information has been added to the messages to aid in the decision-making process. Sites now have the ability to suppress the messages generated for patients who have active health insurance.
- Means Test billing data may now be transmitted between facilities to assist in the preparation of bills for inpatients who transfer between facilities. This functionality works in conjunction with the PDX v1.5 software package.
- Sites routinely experience problems at the beginning of each fiscal year when the new outpatient copayment rate is not available. When the new rate is released to the field, outpatient copayment charges billed since the beginning of the fiscal year require manual editing. In this version, these charges will not be automatically billed to the patient if the effective date of the copayment rate is over one year old. The charges will be held in billing, and once the new rate is

## I. FUNCTIONAL DESCRIPTION, CONT.

entered, all of the charges held up in billing will be passed to the Accounts Receivable package.

This release will also support the enhanced patient statement which is being introduced in Accounts Receivable v4.0. The new statement will provide detailed information for billed prescriptions, outpatient visits, and admissions.

Direct billing to CHAMPVA patients is also supported in this release. CHAMPVA inpatients are required to pay a \$9.30 daily subsistence charge which is not to exceed \$25.00 for an admission. This functionality will not be activated until the AR package releases a patch that allows AR to process CHAMPVA receivables.

## II. CHANGED OPTIONS

### **Cancel/Edit/Add Patient Charges** [IB CANCEL/EDIT/ADD CHARGES]

This option is used primarily to add, cancel, and edit Means Test charges. Many cosmetic, technical, procedural, and functional changes have been made to this option. The charges list has been modified. The user interface has been changed consistently for all actions. The display of billing clock information has been enhanced.

#### **Actions**

Add a Charge - The ordering of prompts has been modified. Charges added for special inpatient billing cases are recognized and are automatically dispositioned. The entry of per diem and inpatient copayment charges has been simplified. CHAMPVA charges may be added after the AR package releases a patch that allows AR to process CHAMPVA receivables.

Cancel a Charge - Many new cancellation reasons have been added. The cancellation logic has been improved.

Edit a Charge - The edit procedure has been simplified. The dialogue has been separated from processing. The edit logic is improved.

Update Events - This new List Manager function allows you to manage the event records created in conjunction with inpatient charges.

Change Status - This action is used if the status of the event record must be changed from OPEN to CLOSED, or vice versa.

## II. CHANGED OPTIONS, CONT.

### **Cancel/Edit/Add Patient Charges, cont.**

Last Calc Date - This action is used to change the date that charges were last calculated for an admission.

### **Outpatient Registration Events Report [IB OUTPUT EVENTS REPORT]**

This report has been enhanced to display whether the outpatient encounters listed on the report were related to claimed exposures, and if those classification questions were answered at checkout. Also, patients with active insurance or those who have claimed exposures are flagged on the report. You may stop the report if it has been queued.

## III. NEW OPTIONS

### **List Charges Awaiting New Copay Rate [IB MT LIST HELD (RATE) CHARGES]**

This report may be used to generate a list of all charges which are being held in billing awaiting the entry of the new Means Test outpatient copay rate.

### **Release Charges Awaiting New Copay Rate [IB MT REL HELD (RATE) CHARGES]**

If charges are being held in billing awaiting entry of the new Means Test outpatient copay rate, and the new rate is entered, all of the charges being held need to be passed to Accounts Receivable. This option recognizes whether there are held charges which need to be billed and allows you to queue a job to bill all charges on hold awaiting the new rate.

### **List Special Inpatient Billing Cases [IB MT LIST SPECIAL CASES]**

If a Category C inpatient has claimed exposure to Agent Orange, Ionizing Radiation, or Environmental Contaminants, there is no reliable and timely way to determine (electronically) whether the admission was related to the claimed exposure. These admissions are stored as special inpatient billing cases. This option lists all special inpatient billing cases for a site with the final billing disposition.

### **Disposition Special Inpatient Billing Cases [IB MT DISP SPECIAL CASES]**

Special inpatient billing cases are not billed automatically. Once the case has been determined to be billable or non-billable, action must be taken to disposition the special inpatient billing case. If the case is not to be billed, this option is used to enter the reason for not billing.

### III. NEW OPTIONS, CONT.

#### **Flag Stop Codes/Dispositions/Clinics** [IB MT FLAG OPT PARAMS]

Outpatient Encounters which are recorded in the Scheduling package as either registrations or stand-alone stop codes will be billed automatically as those events are checked out. This option is used to flag (or unflag) stop codes and dispositions which should not be billed. This option may also be used to flag clinics where Means Test billing is not appropriate.

#### **List Flagged Stop Codes/Dispositions/Clinics** [IB MT LIST FLAGGED PARAMS]

This option is used to generate a list of all stop codes, dispositions, and clinics which have been flagged as not being billable for Means Test billing.

### IV. IMPLEMENTATION GUIDELINES

There is no preparation required by the facility to use the Patient Billing module of Integrated Billing version 2.0. However, the following guidelines are suggested.

Make a list of all stop codes, dispositions, and clinics where the billing of the Means Test outpatient copayment is not desired. These values may easily be entered into the system (utilizing the option Flag Stop Codes/Dispositions/Clinics [IB MT FLAG OPT PARAMS]) from the list.

Decide whether you would like to suppress the generation of mail messages for insured patients who have been billed Means Test copayments. If you wish to suppress these messages, update the Suppress MT Ins Bulletin parameter using the option MCCR Site Parameter Enter/Edit [IB MCCR PARAMETER EDIT].

### V. NEW OR CHANGED MAIL MESSAGES

There are several new and changed mail messages in the Patient Billing module. Please note that the members of the current Category C Billing mail group (IB CAT C) are the recipients of all of these messages, with the exception of the message generated after the tasked job to bill copayment charges awaiting the new copay rate is completed.

#### **New Mail messages**

Special Inpatient Admission - When a Category C veteran who has claimed exposure to Agent Orange, Ionizing Radiation, or Environmental Contaminants is admitted, a mail message is generated to explain that a special inpatient billing case has automatically been generated for the patient.

V. NEW OR CHANGED MAIL MESSAGES, CONT.

**New Mail messages, cont.**

Special Inpatient Discharge - When a Category C veteran who has claimed exposure to Agent Orange, Ionizing Radiation, or Environmental Contaminants is discharged, a mail message is generated to explain that you must decide whether or not to bill the patient within 45 days.

Disposition Special Inpatient Billing Case - If a special inpatient billing case has not been dispositioned within 45 days from the discharge date, a reminder to disposition the case is generated.

Billing of Stop Codes Exempt from Classification - There are a series of stop codes which are exempt from the classification questions in the checkout process. If one of these stop codes is filed for a Category C veteran who has claimed exposure, there is not enough information available to determine if the patient should be billed. The system will bill the patient, then issue a mail message advising you to check the patient's medical record to determine if the patient's care was actually related to the claimed exposure. If the care was related to the claimed exposure, the charge should be cancelled using the Cancel/Edit/Add patient Charges [IB CANCEL/EDIT/ADD CHARGES] option.

Billing of Charges Awaiting New Copay Rate - If the new Means Test outpatient copay rate is being added, and there are copay charges on hold awaiting the new rate, you may queue a job which will automatically bill all of the charges awaiting the new rate (you may also queue this job using the option Release Charges Awaiting New Copay Rate [IB MT REL HELD (RATE) CHARGES]). When the queued job is completed, a mail message is sent to you (not to the Category C Billing mail group) which contains the job start and end date/times, and the number of charges passed to the Accounts Receivable module.

CHAMPVA Admission - A mail message is generated when a CHAMPVA patient is admitted. The message explains that the inpatient subsistence charge (which is billed directly to the patient) will be automatically generated when the patient is discharged. This functionality will not be activated until the AR package releases a patch that allows AR to process CHAMPVA receivables.

Edited/Deleted CHAMPVA Discharge - If a discharge for a CHAMPVA patient is either edited or deleted, the subsistence charge may need to be edited. This mail message alerts you to check the subsistence charge which was billed and determine if it needs to be edited or deleted. This functionality will not be activated until the AR package releases a patch that allows AR to process CHAMPVA receivables.



## V. NEW OR CHANGED MAIL MESSAGES, CONT.

**New Mail messages, cont.**

Error in Billing/Cancelling CHAMPVA Subsistence Charge - The system will generate an error mail message if a logical error (system cannot determine the billable rate, etc.) occurs while creating or cancelling a CHAMPVA subsistence charge. This functionality will not be activated until the AR package releases a patch that allows AR to process CHAMPVA receivables.

**Changed Mail Messages**

Changes in Patient Movements - This existing mail message has been changed so that it will only be generated if either a patient movement date or billable bedsection (derived from the Facility Treating Specialty) has been changed, and the patient has previously been billed for the admission. The actual changes to the movement date and bedsection are included in the message.

Changes in Means Tests - If a change in a patient's Means Test places the patient in Category C, and the patient has received care since the effective date of the Means Test, a mail message will be generated which lists the episodes of care which may potentially be billed. If a change in a patient's Means Test removes a patient from Category C, and the patient has been billed Means Test charges since the effective date of the Means Test, a mail message is generated which lists the charges which may need to be cancelled. If a Category C patient is billed the outpatient copayment charge on the current date, and later on in the day takes a new Means Test which places the patient outside of Category C, the copay charge is automatically cancelled. The mail message which is generated will state that the listed charge has been cancelled.

Means Test Charge Billed to Insured Patient - This mail message has not been changed, but the site may elect to suppress the generation of this message. This may be done by changing the Suppress MT Ins Bulletin parameter in the MCCR Site Parameter Enter/Edit option [IB MCCR PARAMETER EDIT].

## Section 5. Third Party Billing

### I. FUNCTIONAL DESCRIPTION

The Third Party Billing module of Integrated Billing contains the functionality to create bills for insurance companies and other third party payers. The IB v2.0 release includes enhancements to the previously existing functionality. The HCFA-1500 has undergone major modifications. There is new functionality that, in conjunction with the Claims Tracking module, will automatically create bills.

#### **General Third Party Billing Changes**

The Length of Stay and charge calculations have been modified to count the admission date rather than the discharge date to be consistent with patient billing. This calculation has also been changed to calculate inpatient interim bills differently. Previously, interim bills had to be overlapped for the correct number of days to be counted. However, because bills could not cross the fiscal or calendar year, interim bills covering those date ranges could not be overlapped. This resulted in the automatic calculation of Length of Stay and the number of days charged being inaccurate. To correct these problems, the new Length of Stay calculation counts each day on inpatient interim first and interim continuous bills. Inpatient interim bills should no longer be overlapped. The beginning of each bill should be one day after the end date of the last bill.

The UB-82 claim form had five form locators for diagnoses. This has been expanded to nine form locators on the UB-92. This expanded functionality was not provided by IB v1.5 Patch 19 when the UB-92 was first released. This capability is provided in v2.0. Also added is the ability to enter a print order for each diagnosis, similar to the print order for procedures. You will no longer need to rearrange the position of the diagnoses, only the print order. The principle diagnosis should always be the diagnosis with the lowest print order.

CHAMPVA has been added as a new Rate Type. This will allow CHAMPVA bills to be created and passed to Accounts Receivable. This functionality will not be activated until the AR package releases a patch that allows AR to process CHAMPVA receivables.

## I. FUNCTIONAL DESCRIPTION, CONT.

Both prescription refills and prosthetic items have been added to the enter/edit and print bill functions. On the UB-92, these items will be printed as free text in the Revenue Code block, as additional procedures have been. Since the space available on the HCFA-1500 form is limited, an addendum sheet has been added to print the relevant information for all prescription refills and prosthetic items on a bill. Several parameters have been defined to help in the creation of the Prescription Refill bills. These are listed under Implementation Guidelines.

A new option has been added to print bills in a user-specified order. Bills that have been authorized but not yet printed may be printed in order of their mailing address zip code, insurance company name, and/or the patients name.

Functionality has been added to allow the entry and edit of Occurrence Spans and a limited number of Value Codes for the UB-92.

Additional entries have been made to the following lists.

- Discharge Status
- Rate Type
- Revenue Codes

### **HCFA-1500 Claim Form**

The HCFA-1500 functionality has changed significantly in IB v2.0. The form has been expanded to include inpatient as well as outpatient claims so that inpatient professional fees can now be billed on the HCFA-1500. The form has been expanded to allow for multiple pages. There is no longer a maximum number of procedures allowed. The version of the printed form in use at most sites contains a series of black bars where the mailing address was being printed. A new site parameter, HCFA-1500 ADDRESS COLUMN, will allow specification of the column in which the mailing address should begin printing.

The PLACE OF SERVICE and TYPE OF SERVICE have been changed so that they can be entered for each procedure rather than having one of each for each bill. Also, the number of ASSOCIATED DIAGNOSES for each procedure has been expanded from one to four.

## I. FUNCTIONAL DESCRIPTION, CONT.

The Visit CPT has been removed. This was being used to specify with which CPT procedure the outpatient charge would be associated. The new version has been expanded to allow any Revenue Code to be entered and the charge functionality is now the same as that for the UB forms. However, the HCFA-1500 form does not allow for Revenue Codes. Each charge must be associated with a CPT procedure. To facilitate coordination between CPT procedures and Revenue Codes, PROCEDURE and DIVISION fields have been added to all Revenue Codes being added to a HCFA-1500. If this information is entered, the Revenue Code charge will be associated with that procedure on the printed form.

The following rules are used to coordinate the expanded functionality of Revenue Codes and charges associated with procedures as required in Block 24.

- The procedures entered on Screens 4 and 5 are printed first according to specified Print Order.
- If a procedure and division added to a Revenue Code (on Screens 6/7) match one of the CPT procedures (from Screens 4/5), that Revenue Code's charge is printed on the same line item on the bill as the procedure.
- Any remaining Revenue Code charges will be printed on the first available CPT line item, i.e., on the line of the first procedure that does not already have a charge.
- If the procedure for the Revenue Code does not match any CPT procedure entered on Screens 4/5, the procedure and charge are printed following all procedures entered on Screens 4/5.
- If the Revenue Code does not have an associated procedure and the charge cannot be matched with any procedure from Screens 4/5, the line item will be printed last (with Block 24d containing the Revenue Code name and bedsection).

Please note that to match procedures and Revenue Codes, the number of units must also match.

Offsets are now allowed and will be printed after all charges and procedures.

A Bill Addendum sheet has been provided to list all RX refills and prosthetic items and their associated information, since not all required information can fit on the HCFA-1500 form. This sheet may be printed for each HCFA-1500 that has prescription refills or prosthetic items.

## I. FUNCTIONAL DESCRIPTION, CONT.

### **Automated Biller**

The new functionality of the Automated Bill for Integrated Billing v2.0 builds on the previously existing Third Party functionality and the new Claims Tracking module. If the new Claims Tracking module in IB v2.0 is being used for the tracking of inpatient admissions, outpatient visits, or prescription refills for veteran patients with insurance, these records can be used to automatically create reimbursable insurance bills. The status of these bills will be ENTERED/NOT REVIEWED and they should be processed as any other bills with that status.

There are a variety of parameters that allow each site to control what type of event is automatically billed and when.

- The AUTO BILLER FREQUENCY parameter is used to determine if and how often the Auto Biller will run. This is the number of days between each successive execution of the Auto Biller. Using this parameter, a site may specify that the Auto Biller run every night, once a week, etc. This should be set to zero (or left blank as it is released) if the Auto Biller should not run.
- The INPATIENT STATUS (AB) parameter allows the site to specify at what point in the PTF cycle the auto bill should be created. The Auto Biller cannot create a bill for an inpatient admission before the PTF record is CLOSED. Some sites may want to wait until the PTF has been TRANSMITTED. For inpatient admissions, this overrides the DAYS DELAY parameter. No inpatient bill will be created by the Auto Biller until its PTF record is either CLOSED or matches the status set in this parameter.
- The AUTOMATE BILLING parameter controls the amount of user interaction required for automatic bill creation. Bills will be automatically created only for those Claims Tracking events that have an EARLIEST AUTO BILL DATE. The setting of the EARLIEST AUTO BILL DATE for an entry may be accomplished automatically when the entry is created in Claims Tracking if the AUTOMATE BILLING parameter is set. This can be set for each type of event in Claims Tracking that can be automatically billed. Currently, this is limited to inpatient admissions, outpatient visits, and prescription refills. If this site parameter is not set to "YES", the Auto Biller can still be used; however, you must specifically set EARLIEST AUTO BILL DATE for any events for which the Auto Biller should create a bill.

I. FUNCTIONAL DESCRIPTION, CONT.

- The BILLING CYCLE parameter controls the maximum number of days allowed to be billed on a single bill. This can also be specified for each type of event in Claims Tracking that can be automatically billed. Currently, this is limited to inpatient admissions, outpatient visits, and prescription refills. For inpatient bills, this is the maximum Length of Stay for INTERIM or ADMIT THRU DISCHARGE bills. If the patient is discharged, the bill's date range may be less than the billing cycle. For outpatient visits, this is the maximum number of visit dates allowed on a bill. For example, if the outpatient billing cycle is set to "3", the bill may have a date range of three days with three outpatient visit dates. If the patient had only one visit within the three consecutive day period, the bill will have a date range of one day and only the single outpatient visit date.
- An additional parameter, DAYS DELAY, controls the minimum number of days after certain events occur that a bill may be created. This parameter is used at two different points to determine if a bill should be created. The first time is when the Claims Tracking entry is first created. If the AUTOMATE BILLING parameter is set to "YES", the EARLIEST AUTO BILL DATE will be set to the current date plus the number of DAYS DELAY when the Claims Tracking entry is first created. After that date, the Auto Biller will continuously test the event to see if it is ready to be billed. The second time this parameter is used is when the Auto Biller is trying to set up a date range for the bill. In this case, DAYS DELAY is added to the BILLING CYCLE to determine if the correct amount of time has elapsed for the bill to be created. Therefore, a bill will not be created until DAYS DELAY after the BILLING CYCLE. For example, if DAYS DELAY is "3" and BILLING CYCLE is "10", a bill will not be created for at least thirteen days after the initial entry was created in Claims Tracking.

This delay is set up to allow time between the date the event actually occurred and the date a bill is created for any pre-processing of events that need to be done, such as insurance verification. This will also accommodate any delays, such as late entry of events or information. (For example, if outpatient visits are generally not coded for five days, the DAYS DELAY should be at least "5".)

Inpatient admissions are handled slightly differently. The Auto Biller cannot create a bill for an inpatient stay until after the PTF record for that stay is CLOSED. Therefore, for an inpatient admission, the Auto Biller will wait until the number of DAYS DELAY after the status either changes to CLOSED or matches the INPATIENT STATUS (AB) parameter.

## I. FUNCTIONAL DESCRIPTION, CONT.

The Automatic Biller searches through the Claims Tracking file for entries that have an EARLIEST AUTO BILL DATE not greater than the current date. Any entry with this field not set will not be automatically billed, whether the event is billable or not. If the EARLIEST AUTO BILL DATE is set for the event by the system, it will be set to the date the event was entered into Claims Tracking plus the number of DAYS DELAY. This date will be the first date on which the Auto Biller will attempt to create a bill for the event. Which events are automatically billed can be manually specified by using the Claims Tracking module and entering or deleting the EARLIEST AUTO BILL DATE for the event.

When the Auto Biller runs, it will first attempt to create a bill for any event with an EARLIEST AUTO BILL DATE not greater than the current date. The number of outpatient visits on a bill will be determined by the BILLING CYCLE parameter. Although inpatient bills cannot be created until the PTF status is at least CLOSED, the bills created will still follow the Length of Stay defined by the Inpatient Admission BILLING CYCLE.

The results of the execution of the Auto Biller are listed in the Automated Biller Errors/Comments Report. For Claims Tracking events, this report will list either the reason no bill was created or the bill number (and possibly comments) on the bill.

The Auto Biller checks a variety of data elements concerning an event before a bill is created. It will only attempt to create reimbursable insurance bills so the patient must be a veteran with active insurance. The disposition prior to the event date is checked and if NEED WAS RELATED TO AN ACCIDENT or the NEED WAS RELATED TO OCCUPATION, the event may be either Tort Feasor or Workers Comp, and the Auto Biller will not create a bill. Since Dental is usually billed separately, any event with a Dental Clinic stop will be excluded.

The Auto Biller also checks to ensure that the event has not already been billed. For outpatient bills, it will not set up a bill for an outpatient visit already included in another uncanceled bill. For inpatients, it checks to see if the event is already on another bill. If that bill is a final bill (either INTERIM-LAST or ADMIT THROUGH DISCHARGE), another bill will not be created. If the inpatient event does not have a final bill, the Auto Biller will create the new bill with a beginning date immediately after the ending date of the already existing bill.

A comment of explanation will be added to the AUTOMATED BILLER ERRORS/COMMENTS report for the event in any of the previous cases. Also, no bill will be created.

## I. FUNCTIONAL DESCRIPTION, CONT.

For the Claims Tracking Record, if a bill was successfully created, the bill number will be entered into the INITIAL BILL NUMBER field and the EARLIEST AUTO BILL DATE field will be deleted (if the bill was a final bill) for the event. Once a bill has been set up, the Auto Biller continues and attempts to gather as much information as is available. For inpatients, diagnosis and procedures are gathered from the PTF record. Procedures and diagnoses are added for outpatient visits. Additional comments are added to the Automated Biller Errors/Comments Report for the event if the visit is for an SC condition or if any of the movements are for SC conditions or non-billable bedsections.

Entries are removed from the Automated Biller Errors/Comments Report in the following two ways.

- When the bill is either printed or canceled.
- If no bill was created, the option Delete Auto Biller Results [IB CLEAN AUTO BILLER LIST] must be used to delete the entry.

## II. CHANGED OPTIONS

### **Authorize Bill Generation** [IB AUTHORIZE BILL GENERATION]

Modified to use the updated billing screens if the bill is edited within this option.

### **Cancel Bill** [IB CANCEL BILL]

Modified so that comments on the Automated Biller Errors/Comments Report are deleted for each bill cancelled that was initially created by the Automated Biller.

### **Copy and Cancel** [IB COPY AND CANCEL]

Updated to copy the new data fields that can be entered using the Enter/Edit Billing Information [IB EDIT BILLING INFO] option from the old bill to the new bill. Also, when a bill that was created by the Automatic Biller is cancelled, the Automatic Biller comments entry will be deleted from the Automated Biller Errors/Comments Report.

### **Enter/Edit Billing Information** [IB EDIT BILLING INFO]

This has been changed to reflect changes to diagnoses, HCFA-1500, and Insurance Data Capture. Please note that there are several pieces of information on the screens that only apply to the UB-92; however, these will also be displayed for the HCFA-1500. For example, the provider numbers on Screen 3 and the covered and non-covered days on Screens 6 and 7 only apply to the UB-92.



## II. CHANGED OPTIONS, CONT.

### **Enter/Edit Billing Information, cont.**

Screen 3 - This screen has been modified so that the form type will only be displayed and is editable if the site has multiple form types available to you. Note that in this instance the UB-82 and the UB-92 are considered a single form. For a site to have multiple forms, it would use one of the UB forms and the HCFA-1500. This is the same functionality initially released with IB v1.5; however, it was modified by IB v1.5 Patch 19 so that the transition between the UB-82 and the UB-92 would be visible to you.

Entry and editing of insurance information on Screen 3 has changed to conform with the new insurance module information.

Screen 3 of the UB-92 - Entry and editing of a provider number associated with each of the three possible insurance carriers has been added to this screen. These fields will be loaded with the Hospital Provider Number of the associated insurance company, if it has data.

Screen 4 of the HCFA-1500 - Included add/edit of Occurrence Code State.

Screens 4 and 5 - Entry and editing of diagnoses on Screens 4 and 5 has been modified so that more than five diagnoses can be entered. Only five will be displayed on the screen. Also added was the ability to enter a print order for each diagnosis, similar to the print order for procedures.

Prosthetic items have been added to both inpatient and outpatient bills.

Screen 4 and 5 of the UB-92 - Occurrence Spans have been added as a subset of Occurrence Codes. If an Occurrence Span is picked for entry, the date will be considered the beginning date and the end date will be asked. A limited number of Value Codes have been defined and can be added to a bill on these screens.

Screens 4 and 5 of HCFA-1500 - Place of Service and Type of Service have been added so that they are now entered for each procedure. There is no longer a maximum number of procedures that can be entered. Associated Diagnosis has been expanded to four diagnoses.

Screen 5 - Prescription refills can now be added to outpatient bills. The Number of Days Supply, Quantity, and NDC Number may be added to each prescription refill for printing on the bill (if required by the primary insurer).

## II. CHANGED OPTIONS, CONT.

### **Enter/Edit Billing Information, cont.**

Screen 6 - Modified the Length of Stay and charge calculation to count the admission date rather than the discharge date. Also, modified inpatient INTERIM-CONTINUOUS and INTERIM-FIRST bills to add every day of the bill's date range to the charge calculation. Interim inpatient bills should no longer be overlapped.

Screen 6 and 7 of the UB-92 - The BC/BS provider number has been removed from this screen. The UB-92 does not have a specific field for the BC/BS provider number as the UB-82 did. The provider number for each insurance company can now be entered on Screen 3.

The number of days covered and not covered by the primary payer has been added.

Screen 6 and 7 of HCFA-1500 - The Visit CPT has been removed. Revenue codes and their corresponding data can now be added. The charge functionality is now the same as that for the UB forms. Offsets are now allowed. Also, CPT procedure and division may now be entered for each Revenue Code.

Screen 8 of the UB-92 - Admitting Diagnosis has been changed from a free text entry to an actual ICD-9 diagnosis code. Entry and editing of UB-92 Unlabeled Form Locators 2, 11, 31, 37, 56, 57, and 78 have been added to this screen.

Screen 8 of the HCFA-1500 - Entry and editing of Block 31 has been added. Place of Service, Type of Service, and Bill Remarks have been removed from this screen.

### **Insurance Payment Trend Report [IB OUTPUT TREND REPORT]**

An additional column has been added to this report to reflect the actual amount of the bill that is pending collection. If the report is queued, you may stop it.

### **Print Bill [IB PRINT BILL]**

Modified to display during the review and print all new data elements that can be added to a bill. When printing a HCFA-1500 with prescription refills or prosthetic items, the Bill Addendum Sheet will automatically print if a device has been selected for it. When a bill that was created by the Automatic Biller is printed, the Automatic Biller comments entry will be deleted from the Automated Biller Errors/Comments Report.

## II. CHANGED OPTIONS, CONT.

### **Third Party Billing Menu** [IB THIRD PARTY BILLING MENU]

The name of this menu has been changed from UB-82 Menu [IB UB-82 MENU].

The following new options have been added to this menu.

- Delete Auto Biller Results [IB CLEAN AUTO BILLER LIST]
- Print Authorized Bills [IB BATCH PRINT BILLS]
- Print Auto Biller Results [IB OUTPUT AUTO BILLER]
- Print Bill Addendum Sheet [IB PRINT BILL ADDENDUM]

## III. NEW OPTIONS

### **Delete Auto Biller Results** [IB CLEAN AUTO BILLER LIST]

Deletes entries from the Automated Biller Errors/Comments Report for any entry not associated with a bill before a given date. This option has been added to the Third Party Billing Menu [IB THIRD PARTY BILLING MENU].

### **Employer Report** [IB OUTPUT EMPLOYER REPORT]

This report searches for all events (either inpatient admissions or outpatient visits) for non-deceased, non-insured patients within a user-specified time frame. The patient is added only if the patient or patient's spouse is employed or has an employer listed. The report is sorted by employer name. It lists the employer address and various information pertaining to the patient and employed person. This report has been added to the Patient Billing Reports Menu [IB OUTPUT PATIENT REPORT MENU].

### **Enter/Edit Automated Billing Parameters** [IB AUTO BILLER PARAMS]

This option has been added to the MCCR System Definition Menu [IB SYSTEM DEFINITION MENU]. It is used to enter or edit the parameters controlling the execution of the Automated Biller.

### **Print Authorized Bills** [IB BATCH PRINT BILLS]

Prints all authorized bills in a user-specified order. This option has been added to the Third Party Billing Menu [IB THIRD PARTY BILLING MENU]. If a HCFA-1500 with prescription refills or prosthetic items is printed in the batch, the Bill Addendum Sheet will automatically print if a device has been selected for it. If a bill that was created by the Automatic Biller is printed, the Automatic Biller comments entry will be deleted from the Automated Biller Errors/Comments Report.

## II. NEW OPTIONS, CONT.

### **Print Auto Biller Results** [IB OUTPUT AUTO BILLER]

Prints the Automated Biller Errors/Comments Report sorted by date. This option has been added to the Third Party Billing Menu [IB THIRD PARTY BILLING MENU].

### **Print Bill Addendum Sheet** [IB PRINT BILL ADDENDUM]

Prints a Bill Addendum Sheet that may accompany HCFA-1500 bills with RX refills or prosthetic items. This sheet will itemize the refills and prosthetic items on a bill with information that will not fit on the HCFA-1500 form itself. This option has been added to the Third Party Billing Menu [IB THIRD PARTY BILLING MENU].

## IV. IMPLEMENTATION GUIDELINES

If your site wishes to use the Automated Biller, enter the values appropriate to your site to control the execution of the Automated Biller. Use the Enter/Edit Automated Billing Parameters [IB AUTO BILLER PARAMS] option.

AUTO BILLER FREQUENCY:	Enter the number of days between each execution of the Automated Biller. (For example, enter "7" if you want bills created only once a week.)
INPATIENT STATUS (AB):	Enter the status in which the PTF record should be before the Auto Biller can create a bill. No auto bill will be created unless the PTF status is at least CLOSED, regardless of how this parameter is set.

The following parameters may be entered for inpatient admissions, outpatient visits, and prescription refills.

AUTOMATE BILLING:	Enter "YES" if bills should be automatically created for possible billable events with no user interaction. Leave this blank if your site prefers each event to be manually checked before a bill is created by the Auto Biller.
BILLING CYCLE:	For each type of event, enter the maximum date range of a bill. If this is left blank, the date range will default to the event date through the end of the month in which the event took place. For inpatient interim bills, this will be the next month after the last interim bill.
DAYS DELAY:	Enter the number of days after the end of the BILLING CYCLE that the bill should be created.

## IV. IMPLEMENTATION GUIDELINES, CONT.

The following parameters may be used by sites to control prescription refill billing data and charge calculation. If your site plans to implement Prescription Refill billing, enter the appropriate values using the MCCR Site Parameter Enter/Edit [IB MCCR PARAMETER EDIT] option.

DEFAULT RX REFILL REV CODE:	Enter the Revenue Code that should be used for most prescription refill bills. If this Revenue Code is defined, charges for every prescription refill will automatically be added to the bill with this Revenue Code. If left blank, the standard Pharmacy Revenue Code (250) will be used. This site parameter may be overridden by the INSURANCE COMPANY (#36) file parameter PRESCRIPTION REFILL REV. CODE.
DEFAULT RX REFILL DX:	If applicable, enter a diagnosis code that should be added to every prescription refill bill.
DEFAULT RX REFILL CPT:	If applicable, enter a CPT code that should be added to every prescription refill bill.

The following are other new site parameters that may need to be set using the MCCR Site Parameter Enter/Edit [IB MCCR PARAMETER EDIT] option.

HCFA-1500 ADDRESS COLUMN:	For the HCFA-1500, enter the column number in which the mailing address should begin printing for it to show in the envelope window (if it does not already print in the appropriate place).
UB-92 ADDRESS COLUMN:	For the UB-92, enter the column number in which the mailing address should begin printing for it to show in the envelope window (if it does not already print in the appropriate place).

If the Bill Addendum Sheet should automatically print for every HCFA-1500 with prescription refills or prosthetic items, set the DEFAULT PRINTER (BILLING) field for the BILL ADDENDUM form type to the appropriate device. (Use the Select Default Device for Forms [IB SITE DEVICE SETUP] option.)

If certain insurance companies require a specific Revenue Code to be used for Rx refills that is different than the DEFAULT RX REFILL REV CODE field, use the option Insurance Company Entry/Edit [IBCN INSURANCE CO EDIT] to enter the required Revenue Code in the PRESCRIPTION REFILL REV. CODE field.

## V. MISCELLANEOUS CHANGES

### **Billing Rates List** [IB LIST OF BILLING RATES]

This output has been modified to include the new CHAMPVA inpatient subsistence rates and limits.

### **Enter/Edit Billing Rates** [IB BILLING RATES FILE]

This option has been modified to allow the entry of the CHAMPVA inpatient subsistence rate and limit. If a new Means Test outpatient copayment rate is entered, and there are charges on hold awaiting the new rate, you may queue a job to bill all the charges on hold.

### **Fast Enter of New Billing Rates** [IB FAST ENTER BILLING RATES]

If a new Means Test outpatient copayment rate is entered, and there are charges on hold awaiting the new rate, you may queue a job to bill all the charges on hold.

### **Find Billing Data to Archive** [IB PURGE/FIND BILLING DATA]

Instead of archiving exclusively by fiscal year, you may archive and purge through a specified date. Interim claims may only be archived and purged if the final claim may be archived and purged.

### **MCCR Site Parameter Enter/Edit** [IB MCCR PARAMETER EDIT]

This option has been updated so that the following parameters may be entered.

- Default Rx Refill Rev Code
- Default Rx Refill Dx
- Default Rx Refill CPT
- HCFA-1500 Address Column
- Suppress Means Test Insurance Bulletins (Yes/No)
- UB-92 Address Column

### **MCCR System Definition Menu** [IB SYSTEM DEFINITION MENU]

The new option Enter/Edit Automated Billing Parameters [IB AUTO BILLER PARAMS] has been added.

### **Patient Billing Reports Menu** [IB OUTPUT PATIENT REPORT MENU]

The option UB-82 Test Pattern Print [IB UB-82 TEST PATTERN PRINT] has been removed from this menu. The new option Employer Report [IB OUTPUT EMPLOYER REPORT] has been added to this menu.

### **Third Party Billing Menu** [IB THIRD PARTY BILLING MENU]

This is the new name for the UB-82 Menu [IB UB-82 MENU].



## Section 6. Obsolete Components

### Obsolete Routines

The following DGCR\* routines are now obsolete and may be deleted from your system.

DGCRA	DGCRA0	DGCRA1	DGCRA2	DGCRA3	DGCRA31	DGCRA32	DGCRAMS1
DGCRAMS2	DGCRB	DGCRB1	DGCRB2	DGCRBB	DGCRBB1	DGCRBB2	DGCRBR
DGCRBULL	DGCRC	DGCRCC	DGCRCC1	DGCRCC2	DGCRCP	DGCRMENU	DGCRNQ
DGCRNQ1	DGCROBL	DGCROMBL	DGCRONS1	DGCRONS2	DGCRONSC	DGCROPV	DGCROPV1
DGCROPV2	DGCROTR	DGCROTR1	DGCROST	DGCROST1	DGCROTR	DGCROTR1	DGCROTR2
DGCROTR3	DGCROTR4	DGCRP	DGCRP0	DGCRP1	DGCRP2	DGCRP4	DGCRPAR
DGCRPAR1	DGCRSC1	DGCRSC2	DGCRSC3	DGCRSC4	DGCRSC4A	DGCRSC4B	DGCRSC4C
DGCRSC5	DGCRSC6	DGCRSC61	DGCRSC7	DGCRSC8	DGCRSC8H	DGCRSCE	DGCRSCE1
DGCRSCH	DGCRSCH1	DGCRSCP	DGCRSCU	DGCRSCV	DGCRST	DGCRST1	DGCRST2
DGCRST3	DGCRST4	DGCRST5	DGCRTN	DGCRTP	DGCRU	DGCRU1	DGCRU2
DGCRU3	DGCRU4	DGCRU5	DGCRU6	DGCRU61	DGCRU62	DGCRU63	DGCRU7
DGCRU71	DGCRVA	DGCRVA0	DGCRVA1	DGCRXX	DGCRXX1	DGCRXX10	DGCRXX11
DGCRXX12	DGCRXX13	DGCRXX14	DGCRXX15	DGCRXX16	DGCRXX17	DGCRXX18	DGCRXX19
DGCRXX2	DGCRXX3	DGCRXX4	DGCRXX5	DGCRXX6	DGCRXX7	DGCRXX8	DGCRXX9

The following IB\* routines are now obsolete and may be deleted from your system.

IBACKIN   IBEP   IBEHCFA   IBEHCF1   IBOHCTP   IBOHCP

### Obsolete Options

The following options are obsolete in IB Version 2.0.

IB MAS BILLING LOG  
IB NEW FEATURES 1.5  
IB REVIEW BILL  
IB OUTPUT BRIEF INQ BY BILL NO  
IB MT DISCH COMP

### Options Exported Out-of-Order

IB MT PASS CONV CHARGES





# Task Group Members

The MCCR Project Manager and Development staff wish to gratefully acknowledge the many contributions to version 2.0 of Integrated Billing by the Task Group members listed below. By sharing their areas of expertise, and providing a number of useful suggestions, these individuals have enabled the development of software which is more closely related to user needs and is more user-friendly. In addition, we would like to thank the MCCR Systems Committee, chaired by James Mashburn, and the MCCR Expert Panel, chaired by William Raymer, for their contributions to the development process.

An IB version 2.0 Task Group Meeting was held at the Century Inn, Latham, New York, from September 22nd to 24th, 1992. Follow up conference calls were also held as needed. During this meeting, the groundwork for the Utilization Review, Insurance, and Encounter Form modules was developed. The following are members of this Task Group.

- Suzanne Caudill, UR Specialist for MCCR, San Diego VAMC
- Susan Fenton, HIM Program Specialist, MAS Program Office, VACO
- Michael Finegan, AFO/MCCR Coordinator, Albany VAMC
- Samuel Georgeson, Chief, Systems Development, MCCR Program Office, VACO
- Carole Gushard, MCCR Coordinator, San Antonio VAMC
- Dr. Ken Hammond, Chair, Problem List EP, American Lake VAMC
- Sandra Jones, MCCR Coordinator, Western Region, Portland VAMC
- James Mashburn, MCCR Systems Committee Chair, San Francisco ISC
- Debra Price, Problem List Developer, Salt Lake City ISC
- Dennis Sather, Management Analyst/MCCR Liaison, MIRM, VACO
- Sandra Snow, UR Coordinator/MCCR Supervisor, Hampton VAMC
- Seldon Todd, Chief, Planning & Innovation Division, MCCR Program Office, VACO

A Patient Billing Task Group for IB version 2.0 was formed in January, 1993. The members of this group, listed below, provided valuable suggestions for this module.

- Susan Adams, MCCR Coordinator, Augusta VAMC
- JoEllen Cannedy, MAS ADPAC, Martinsburg VAMC
- Jamie Coram, MAS ADPAC, Prescott VAMC
- Kevin Fandel, Program Analyst, MCCR Program Office, VACO
- Samuel Georgeson, Chief, Systems Development, MCCR Program Office, VACO
- Dorothy Hess, MCCR Coordinator, Wilkes-Barre VAMC
- Jack Johnson, Assistant Chief, MIS, Bay Pines VAMC
- James Mashburn, MCCR Systems Committee Chair, San Francisco ISC
- William Raymer, Chairman, MCCR Expert Panel, Long Beach VAMC
- Dennis Sather, Management Analyst/MCCR Liaison, MIRMO, VACO
- Irene Smith, MAS ADPAC, Augusta VAMC

A Third Party Billing Task Group was established in February, 1993 to discuss the specifications for the Third Party Billing module in IB version 2.0. The following are members of this Task Group.

- Judith Benfield, MCCR Coordinator, Richmond VAMC
- Steven Bottini, Computer Specialist, San Francisco ISC
- Samuel Georgeson, Chief, Systems Development, MCCR Program Office, VACO
- Jeanette Lommen, Billing Supervisor, Portland VAMC
- Robert Mandelstam, Chief, MAS, Canandaigua VAMC
- James Mashburn, MCCR Systems Committee Chair, San Francisco ISC
- Sharla Miller, MAS Program Assistant, Madison VAMC
- Mary Pena, Chief, MCCR Section, Lexington VAMC
- William Raymer, Chairman, MCCR Expert Panel, Long Beach VAMC
- Karen Sagar, Program Assistant, Martinsburg VAMC
- Dennis Sather, Management Analyst/MCCR Liaison, MIRMO, VACO